



HEALTH CARE REFORM

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Health Care Reform, Serial 103-31, ...

ARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

VOLUME V

Expansion of Medicare Benefits to Include Prescription Drugs

JUNE 22, 1993

Health Care Service Delivery Infrastructure in Inner-City and Rural Communities

JUNE 24, 1993

Implementation of a National Health Budget

JULY 13, 1993

Serial 103-31

Printed for the use of the Committee on Ways and Means



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
FLOOR CLERK'S OFFICE
WASHINGTON, D.C. 20540

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EXPANSION OF MEDICARE BENEFITS TO INCLUDE PRESCRIPTION DRUGS

TUESDAY, JUNE 22, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C.***

The subcommittee met, pursuant to call, at 10:05 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, JUNE 16, 1993

PRESS RELEASE #16
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
HEALTH CARE REFORM: EXPANSION OF
MEDICARE BENEFITS TO INCLUDE PRESCRIPTION DRUGS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health care reform and an expansion of Medicare benefits to include prescription drugs. The hearing will be held on Tuesday, June 22, 1993, beginning at 10:00 a.m., room 3-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark stated: "Many of the health care reform proposals now being discussed for the under 65 population have a minimum benefit package that would include coverage of prescription drugs. However, lack of coverage for prescription drugs remains one of the largest gaps in Medicare coverage for the elderly--a gap which I would like to see closed.

"How to pay for a drug benefit is a key problem. The American pharmaceutical industry has been one of the most profitable and inflationary segments of our economy; its products are often sold overseas at a fraction of the price charged to Americans. I believe that we could afford a reasonable drug benefit for seniors if it were paired with an effective cost-containment strategy for pharmaceutical products."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The cost of prescription drugs has been rising rapidly. Between 1980 and 1987, the average annual cost of prescription drugs for the elderly increased by 14 percent per year. The Health Care Financing Administration has estimated that the average prescription in 1993 will cost \$24.26. Using 1987 usage rates, the average annual cost of prescription drugs per person for the elderly will be \$371 in 1993. Current data indicates that spending on prescription drugs will amount to an estimated \$71 billion in 1993. This accounts for 8.8 percent of total spending on health care services.

While many of the elderly do not have insurance covering prescription drugs, they are high users of these medications. The elderly account for only 12 percent of the population, but for 34 percent of total spending on drugs.

(MORE)

According to a 1989 report to the Congress issued by the Department of Health and Human Services, the average, non-institutionalized Medicare beneficiary used an average of 15.3 prescriptions per year in 1987. In addition, average usage increased somewhat with age. The average number of prescriptions per person has also increased over time. Individuals with functional impairments (measured by two or more limitations in their activities of daily living) used an average of 26.2 prescriptions per year, and individuals in poor health used an average of 31 prescriptions per year.

In 1992, about half of health plans offered by large employers included some form of prescription drug coverage. However, according to the most recent data available, only about 30 percent of outpatient prescription drugs for the elderly were billed to either Medicaid or other third party insurers. An unknown number of the remaining prescriptions may have been submitted to an insurer by the patient.

There is currently no benefit for self-administered, outpatient prescription drugs under Medicare. The Medicare Catastrophic Coverage Act of 1988 had included such coverage, however, this law was repealed in 1989.

There are a variety of important considerations in the design of a prescription drug benefit for the elderly including: financing, patient cost sharing, such as deductibles and coinsurance, and issues relating to cost containment.

A number of recent reports indicate that the current market for prescription drugs may not be an effective mechanism for controlling prices. The Office of Technology Assessment has reported that the pharmaceutical industry has been earning profits from the sale of prescription drugs well in excess of the level needed to pay for its debt from research and development. In addition, the General Accounting Office (GAO) has documented that prices of many drugs have substantially exceeded the rate of general inflation. The GAO also has documented that drug prices in the domestic market are far above the prices charged for the same products in other countries.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, July 6, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

- 1 All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
- 2 Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
- 3 Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
- 4 A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning.

Today's hearing will examine issues related to a Medicare prescription drug benefit. Unlike most other health care expenses, prescription drugs are not covered by Medicare or by many medigap policies.

Many senior citizens require multiple prescriptions each year in order to manage chronic conditions and to treat numerous acute health problems. Without insurance, seniors are forced to pay substantial sums out of pocket for the medications they need to survive.

In 1992, one third of all seniors spent more than \$650 per year for prescription drugs; and 1 in 5 spent over \$1,000 per year.

In some cases, drug costs are so high that beneficiaries simply take a chance and live without their prescribed medications, simply because they can't afford the expense.

While the need for prescription drug coverage is clear, Congress has not yet been able to meet the challenge of providing comprehensive prescription drug coverage.

A Medicare prescription drug benefit was one of the first program modifications considered after enactment of the Medicare program more than 2 years ago. The Senate passed a prescription drug benefit in 1972, but it was never enacted.

After years of experience with public coverage of prescription drugs through the Medicaid and the Veterans' Administration, we enacted a new Medicare drug benefit, as many will recall, under the Medicare Catastrophic Act in 1988. Unfortunately, this benefit was repealed only 1 year later.

I believe that we are again at a point where the real need for a prescription drug benefit must be paramount on our list of issues and concerns.

We will soon take up the issue of health care reform and as part of this reform, it will be necessary to specify a minimum scope of benefits that would constitute basic insurance coverage to be provided to or purchased by the under age 65 population. This minimum package must include coverage of prescription drugs. Currently, 95 percent of group health plans offered through employers provide some basic coverage of prescription drugs. Given the wide availability of such coverage, it will probably be included as part of the basic benefits.

If coverage is provided for the under age 65 population, I can think of no reason not to provide the same or additional coverage for the elderly. The elderly have much greater use of such drugs and greater need for coverage. Requiring broader coverage for the young and ignoring the elderly would create a new notch problem, and none of us need that. On this committee, we are familiar with the political problems that that has caused and we should avoid this issue in health care reform by insuring that the elderly have comparable benefits to those provided to the rest of the population.

There are many issues involved in the design of a drug benefit for the elderly. Principal among them are cost containment, including the pricing of products and the creation of incentives for appropriate use of the drug, such as beneficiary cost sharing, including deductibles and coinsurance; and last but not least, the financing of any program.

I hope that this hearing will provide members with an opportunity to discuss these issues.

Before proceeding, I would like to recognize our Ranking Minority Member, Mr. Thomas, who patiently awaited the Chair's tardy arrival, for his opening statement.

Mr. THOMAS. Thank you, Mr. Chairman.

If we can get to the health care reform package in a time frame equal to your tardiness, none of us would have any problems. You weren't really late.

I agree with the Chairman in terms of the necessity to look at the drug question and treat the nonelderly and the elderly similarly and I wonder if you would extend that to including the entire Medicare program into the new health care reform, because I believe not only should the drug area if necessary be phased in and incorporated, but also the entire Medicare structure.

Chairman STARK. If I had my way, reform would be Medicare for all.

Mr. THOMAS. I don't mean the other way around; all squares or rectangles. The other thing that is frustrating as we continue to move forward in examining particular areas such as drugs is that this committee has a limited jurisdiction. When you talk about areas you touched on which are legitimate in terms of concerns, I am also concerned about the role of government in bringing new drugs to the market, the approval and patent process, the time line for approval for recovery of R&D costs which all lead to particular pricing schemes that if we were to affect that area might provide some cost savings to individuals themselves.

I am also concerned as we move forward with health care that it not just be government intervention that determines the price of drugs or any other cost of health care, but that we make sure that market reforms are in place so that if in fact others outside our system are gaming and gaining by virtue of the way they purchase, we might have that same opportunity in our system.

So I look forward to the testimony from all and hope that people will not be as cognizant of the committee jurisdiction as they might otherwise be because the solution clearly is an interdisciplinary one and an intercommittee one.

I thank the chairman very much.

Chairman STARK. Thank you.

Our first witness today is an old friend of the committee, Bruce Vladeck, who is here for the first time in his new role as Administrator of the Health Care Financing Administration.

Welcome to the committee and in the next few months, I am sure we will see you more often, but why don't you try to enlighten us about the topic of the day.

**STATEMENT OF HON. BRUCE C. VLADECK, ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. VLADECK. Thank you, Mr. Chairman.

I hope it is more than just a few months where I have the opportunity to work closely with members of the subcommittee on the many concerns we share in common, particularly providing better services to our Medicare and Medicaid populations.

There is a formal statement which we have submitted. I will try to summarize the major points this morning, particularly by sharing with you our experience over the last several years in administering the changed statute and regulations for the Medicaid prescription drugs program, which we think has important implications for thinking about how one might construct and implement a Medicare drug program.

We share with you the concern that a large portion of elderly citizens require, on average, more prescription drugs than younger Americans and are without adequate coverage for prescription drugs. That poses serious difficulties in terms of household incomes for many of the elderly and often does indeed have adverse effects on the care they receive.

At the moment, we only cover under Medicare prescription drugs that are primarily used in the inpatient setting. In Medicaid, States have had the option to provide a drug benefit since the program began and every State does. That means more than 22 million Americans who are Medicaid recipients last year received prescription drug coverage and as a result Medicaid is the largest payer for outpatient prescription drugs in the Federal Government.

In fiscal year 1992, Medicaid spent over \$7 billion combined Federal and State funds for prescription drugs, accounting for about 12 percent of the Nation's total expenditures for prescription drugs. We estimate this year in excess of \$8 billion will be Medicaid drug expenditures.

By the late 1980s, it had become evident that Medicaid needed a better system to ensure appropriate utilization of prescription drugs for recipients to constrain the costs and to facilitate processing the growing volume of drug claims.

Together, Congress, HCFA, the Executive Branch, the States and the industry worked together and built a consensus which was reflected in the provisions of OBRA 1990. The resulting Medicaid prescription program involves a three-pronged approach to cost containment and quality assurance through drug utilization review, a rebate program and payment limits.

Drug utilization review requires all States to have in place a mechanism to ensure that prescriptions are appropriate and medically necessary and not likely to result in adverse medical outcomes.

All States are now actively implementing both prospective and retrospective drug utilization review, including counseling and intervention programs with physicians to correct problems identified in prescribing practices as a result.

By the end of this year, 19 States will have electronics claims processing systems in place and 15 States will use these systems to perform prospective drug utilization review. More States will come on board in 1994 and we are looking forward to the day when all Medicaid programs use prospective electronic systems.

The second major element of the Medicaid prescription drug program is the rebate component. Drug manufacturers that want their drugs available to Medicaid recipients must agree to rebate money to the program. In addition, manufacturers must pay additional rebates for those brand name drugs whose prices are increasing more than the overall rate of inflation.

At the moment, 452 manufacturers have entered into rebate agreements, covering over 90 percent of all drugs, including all the most commonly prescribed drugs. In 1992, manufacturer rebates to the Medicaid program totaled \$1.1 billion, of which the Federal share was just over \$650 million, or roughly 15 percent of total program outlays.

In addition to the rebate program, the third part of the Medicaid prescription drug program are payment limits. In OBRA 1990, we augmented the preexisting upper limits and established criteria for adding new drugs. HCFA now sets an upper payment limit for generic drugs at 150 percent of the lowest-priced drug within the class.

I think while we are relatively early in the implementation of this new Medicaid drug program, it appears to be well received by the States, by the beneficiaries, by pharmacists at the retail level, and by the drug companies as well, and we think the savings are real.

We don't know exactly what the design will be of a Medicare prescription drug benefit as part of health care reform, but we think our Medicaid experience provides us a good basis as we begin to consider the challenge of creating and administering a Medicare prescription drug benefit.

We have established a set of relationships with drug manufacturers and the States in developing working relationships, establishing new data and reporting systems relative to drug pricing and drug utilization among elderly Medicaid dual-eligible recipients, and are developing increasing experience with implementing technologically sophisticated billing and processing systems.

The rebate program meets the requirements of the law, it protects proprietary information, and preserves current market interactions and saves the Federal Government and the States a considerable amount of money.

We continue to work on developing a process for resolving disputes that are bound to arise in such complex interactions.

The major challenge for Medicare as we begin to put together a drug benefit would be simply the enormous volume of claims that such a benefit would produce. We estimate that a Medicare drug benefit would generate more than a billion additional Medicare claims annually.

The entire program, parts A and B, this year will pay something on the order of 700 million claims for all other benefits. The number of claims for prescription drugs therefore would be 50 percent greater than all claims in the rest of the system. We feel very strongly that the only way to handle such volume effectively would be by an electronic on-line system in pharmacies which also permits prospective utilization review along with the processing of claims and payment.

While this would be complex to do, it would be much easier to implement such a system than it would have been 5 years ago when we were trying to implement catastrophically. The technology has advanced. The retail pharmacy industry is much more automated than it was in the past, and Medicare's experience with electronic claims processing has moved ahead substantially.

We lead the industry in electronic claims processing. We now process close to 80 percent of hospital claims electronically, well over 60 percent of physician claims. So we have an experience base to move forward with pharmacy claims.

As our technologic capability grows, it also provides an infrastructure that makes it possible to be more responsive to policy changes, to concerns of providers and beneficiaries, and to have a better information base for moving the program forward.

In conclusion, we are proud of the progress we have made with the Medicaid prescription drug program. We think it is working to improve access for beneficiaries, to improve the quality assurance process for prescription drugs in those populations, and it is containing costs. We think this experience would be extremely useful in developing and administering a Medicare drug benefit.

We very much look forward to the prospect of working with you and all the members of the subcommittee in the period ahead to look more precisely at what such a benefit would entail and to move forward as part of a broader effort in health care reform.

Thank you. I would be happy to take any questions you might have.

[The prepared statement follows:]

**STATEMENT OF
BRUCE C. VLADECK
JUNE 22, 1993**

Mr. Chairman, members of the Subcommittee: I am pleased to appear before you for the first time as Administrator of the Health Care Financing Administration. I want to take this opportunity to pledge my cooperation to the members of this Subcommittee as we work to better serve our Medicare and Medicaid populations and secure access to high quality care for all our nation's citizens.

Today, I want to share with you the Health Care Financing Administration's experience administering the Medicaid prescription drug benefit and its implications for an expanded Medicare drug benefit.

BACKGROUND

We know a large portion of the elderly require more prescription drugs than younger Americans. While insurance covers some drug expenses, that coverage declines with age and the elderly often experience difficulty with out-of-pocket payment for their prescription drugs.

The Medicare program does not have an outpatient prescription drug benefit and covers prescription drugs primarily as part of inpatient care. Coverage of drugs on an outpatient basis is limited to certain vaccines, antigens, and immunosuppressive drugs. Beneficiaries can, however, enroll in Medicare managed care programs which frequently cover prescription drugs on an outpatient basis. Also, many Medicare beneficiaries purchase supplemental insurance policies that cover outpatient drugs, or receive coverage for prescriptions from retiree health plans.

States have had the option to provide a drug benefit to Medicaid recipients since the program's establishment twenty-eight years ago. While only a few States elected to provide this benefit initially, now all States cover drugs. As a result, over 22 million Medicaid recipients received drug benefits in 1992.

About 80 percent of elderly Medicaid recipients used prescription drugs, at an average expenditure of about \$760 per recipient in 1992. This represented a more than 14 percent increase over the previous year's average expenditure per Medicaid recipient. We believe that Medicare beneficiaries have a similar experience in prescription drug use. Our

actuaries estimate that about 85 percent of Medicare beneficiaries used prescription drugs in 1992, at an average cost of \$604 per user.

THE MEDICAID EXPERIENCE

The Medicaid program is the largest payer of outpatient prescription drugs in the federal government. In 1992 Medicaid paid over \$7 billion in prescription drug payments, accounting for about 12 percent of the nation's prescription drug bill. The dramatically increasing price of prescription drugs during the 1980s contributed to the financial pressure State Medicaid programs were experiencing. Between 1982 and 1992,

drug prices grew 138 percent compared to the growth of 45 percent in the prices of all consumer goods and services.

By the late 1980s, it became evident that a system was needed to ensure the necessity and appropriateness of Medicaid drug utilization, to constrain costs, and to ease the administrative problems caused by the large volume of claims being processed. Together, Congress, HCFA, the States, and the industry considered various approaches to the development of a program that would improve the purchasing, dispensing, and payment for prescription drugs.

A consensus was forged with the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The resulting Medicaid prescription drug program provides a three-pronged approach to cost containment and quality assurance through drug utilization review, rebates, and payment limits.

Drug Utilization Review (DUR)

The DUR component of the Medicaid prescription drug program is most significant for its impact on quality and its potential implications for an expanded Medicare benefit. The DUR program requires all States to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes. Each State must have a DUR Board and conduct both retrospective and prospective DUR.

- o Retrospective DUR builds on existing systems to conduct ongoing assessments of drug claims data, and provides an educational and intervention program to improve prescribing and dispensing practices.
- o Prospective DUR involves screening for drug therapy problems before each prescription is filled and counseling offered by pharmacies, which must make reasonable efforts to maintain patient profiles.
- o DUR Board members are required to have relevant expertise and are responsible for the application of standards, retrospective DUR, and ongoing interventions concerning problems identified by retrospective DUR.

The DUR requirement has been in effect since January 1, 1993, and all States are actively implementing their programs. I am particularly pleased that 19 States will have electronic claims processing systems in place by the end of this year, 15 of which will be used to perform prospective DUR, including those in California, Maryland, Iowa, and Texas. More States are expected to install electronic claims processing systems in 1994.

States have developed aggressive counseling requirements. All States require pharmacies to offer counseling on new prescriptions, and 42 States require counseling for ALL patients, not just Medicaid recipients. Three-quarters of the States require that offers to counsel be documented. Drugs are also being screened retrospectively for inappropriate prescribing against therapeutic criteria, usually on a

monthly basis. All States send letters to physicians to correct prescribing problems and many States employ face-to-face contact with the physicians.

In September 1992, we funded two demonstration projects, in Iowa and Washington, to test the efficiency and cost effectiveness of electronic, on-line prospective DUR and the effects of paying pharmacists for cognitive services. The projects are now in a 1-year developmental phase, after which they will be operational for up to 3 years.

Manufacturers' Rebates

The second major piece of the Medicaid prescription drug program is the rebate component. Under the OBRA 90 provision, drug manufacturers that want Medicaid payment for their drugs must agree to rebate money to the program. The quarterly rebates for brand name drugs are based on a fixed percentage of the average manufacturer's price or the difference between it and the manufacturer's "best" or lowest price. In addition to this basic rebate, additional rebates are required for brand name drugs if the price of a drug increases quarterly by more than the overall rate of inflation. Manufacturers of brand name drugs must pay Medicaid dollar-for-dollar for increases above this cap. Rebates for generic drugs now are set at 10 percent of the average manufacturers price and will increase to 11 percent in 1994.

Manufacturers joining the rebate program generally have all their drugs covered by State Medicaid programs. To date, 452 manufacturers have entered into rebate agreements, covering over 90 percent of drugs, including all major drugs. In 1992, manufacturer rebates totaled \$1.1 billion, of which \$655 million is the federal share.

The President's budget proposes to permit States to establish formularies to give States more flexibility in administering their prescription drug programs.

Federal Upper Limits on Payment

The third piece of the Medicaid prescription drug program is the payment limits. Payment for prescription drugs grew out of a longstanding policy that specified upper limits for multiple source and "other" drugs. OBRA 90 augmented the federal upper limits and established new criteria for adding new drugs. For generic drugs, HCFA now sets a specific upper limit, at 150 percent of the lowest price drug within the group. Upper limits do not apply if a physician certifies that a specific brand of drug is medically necessary.

PROGRAM SUPPORT

The Medicaid prescription drug program provides incentives for cost containment, and has been generally well-received.

- o Medicaid recipients benefit because prescribed drugs are more often covered, and DUR helps safeguard against improper or unnecessary medication and adverse medical

outcomes.

- o Manufacturers are satisfied because State Medicaid agencies cover their outpatient drugs without direct price controls.
- o States like the program because they receive rebates.
- o The federal government is pleased that it receives a share of the rebate to the Medicaid program and that DUR promises to safeguard quality and be cost effective.

WHAT WE HAVE LEARNED - IMPLICATIONS FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

Obviously, we do not yet know how coverage of prescription drugs will fit into the President's health care reform plan and what that might mean for the Medicare program. Our Medicaid experience, however, certainly stands in good stead as we consider the imposing challenges presented by creating a Medicare prescription drug benefit. Medicaid has established a new and complex prescription drug program, with all the operating systems that such a program entails, and I believe we can look with some pride at what we have accomplished with the States over the last 3 years. HCFA has already been called upon to lend its experience to assist the Public Health Service and the Department of Veterans Affairs in implementing their new drug discount programs.

HCFA has a good track record with drug manufacturers and States in developing working relationships, establishing new data and reporting systems, and implementing billing and processing systems. We have worked together to create a rebate agreement that meets legal requirements, protects proprietary information, and preserves current market interactions. We have created mutually agreeable definitions and a nomenclature to describe our working relationships. And we continue to develop a process for resolving the disputes that are bound to arise in such complex interactions.

Our experience shows that the Medicaid rebate system is providing savings -- at a higher level than originally anticipated -- and the additional rebate appears to be constraining the growth of Medicaid drug prices. Our experience with drug utilization review demonstrates that State are able to establish systems with counseling, drug screening against therapeutic criteria, and appropriate interventions. Importantly, States are actively establishing electronic drug claims processing systems which will be capable of prospective drug utilization review. In addition, these electronic systems protect the integrity of the drug program by inhibiting fraud and abuse.

The major Medicare challenge, of course, is the enormous volume of claims that such a benefit would produce. HCFA estimates that a Medicare prescription drug benefit could produce more than a billion additional claims annually, well above the total current volume, for all the rest of the Medicare program, of 660 million claims. Such volume would

be best handled by electronic on-line systems in pharmacies for drug utilization review and claims payment purposes. Such a system would require sufficient lead time to accommodate the procurement process for system development.

While complex, an electronic drug claims processing system seems much more accessible now than 5 years ago, when we were working on the Medicare catastrophic drug benefit. Currently, Medicare leads the industry in electronic claims processing. Over 88 percent of part A and 62 percent of part B claims are received electronically. Medicare is now developing a state-of-the art Medicare transaction system that will consolidate the current 15 claims processing systems across the country into a single, uniform system at a limited number of sites. As our technological capability grows, it provides a systems infrastructure that will make Medicare more responsive, efficient and effective in our relationships with beneficiaries and providers.

CONCLUSION

In conclusion, we can be proud of the progress to date the Medicaid prescription drug program is demonstrating in meeting the objectives of improved access, quality assurance, and cost containment. The experience HCFA has gained in developing and implementing this complex program will be invaluable in considering a new drug benefit. That said, we must be mindful of the enormous challenge involved in such a new venture and carefully and thoroughly consider all aspects of implementing expanded drug coverage. Mr. Chairman, let me assure you that I look forward to working with you and members of this Subcommittee as you review the possibilities.

I would be pleased to answer any questions you may have.

Chairman STARK. The only thing that comes to mind—and I am sure this will be a topic for some discussion—is that the rebate system which you use in Medicaid is more complicated than the one we used in the catastrophic bill. It never got going, so it is hard to say. What I have trouble with is when you have the rebate system, you necessitate tracking and price monitoring, which in itself is complex and a lot of data.

How many drugs are there; 1,500?

Mr. VLADECK. I think well in excess of that.

Chairman STARK. Roughly.

Mr. VLADECK. Literally thousands and thousands of prescription drugs.

Chairman STARK. If you take in generics, 2,000 to 3,000?

Mr. VLADECK. Several thousand; 2,000 to 3,000, I think. That is our number today.

Chairman STARK. How many codes are there for physicians—seven?

Mr. VLADECK. Something like that. Yes.

Chairman STARK. You guys don't work up a big sweat keeping track of 7,000 physician codes and paying for them? We pay for more than prescription drugs. What I can't understand is why you go through this around the barn six ways and over the top and under to get to the result, which is to set a reasonable price.

Why do all this cockamamy tracking and keeping track and averaging where I suspect you get gamed, and there are three different prices for the drugs, and you worry about volume discounts and unrecorded rebates and package deals? Wouldn't it be simpler and more efficient just to say we are going to establish prices and then track the volume?

You may have to change the price of this new drug, but it doesn't seem that will change the price on 3,000 other drugs every year. You might give them a cost-of-living increase. There may be new drugs. You may have to take old drugs off.

Why wouldn't that be simpler?

Mr. VLADECK. It might well be simpler to establish a price setting system for prescription drugs. From an administrative point of view I am not sure from the government's perspective, it would be necessarily cheaper. It is not clear to me—

Chairman STARK. Cheaper to administer?

Mr. VLADECK. No, cheaper in terms of what you are actually paying for the drugs.

Chairman STARK. I know how to make it that way.

Mr. VLADECK. What happens when you get into any formal rate-setting system is that in an appropriate constitutional process, there are a number of things you are obligated to take into account in terms of the needs and costs of the producers.

Chairman STARK. There are? Where is that written? What about low bid?

Mr. VLADECK. That is closer to what we are now doing.

Chairman STARK. Why don't we do that?

Mr. VLADECK. It might be worth experimenting with a pure bidding model for existing Medicaid programs as well as for a Medicare benefit. I think at the moment the rebate program is permitting the government to get the advantage of its relative market

power as a buyer, and it is not clear to me that direct government-administered prices—depending on how large a share of the market you were setting prices for—gives you a better deal.

We are getting a comparatively better deal than others under the rebates—

Chairman STARK. How come we don't get as good a deal as they get in Canada? We could send somebody from HCFA, rent a U-Haul, load up there and come back and pass them out. It would save about 30 percent off what we are paying.

Mr. VLADECK. I think the real issue is, as Mr. Thomas suggested, that in making policies about drug purchasing and drug pricing, we have looked at them in the context of a whole set of questions about the role of the pharmaceutical industry and its relationship to medical research and to other broad policies.

I am not sure that I could comment in a particularly informed way about those big issues.

Chairman STARK. Would you like to comment about the social justification of the industry as a contributor to the well-being of humanity?

Mr. VLADECK. Not in any comparative terms, no.

Chairman STARK. Just an interesting thought.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. Mr. Vladeck, in your testimony on page 3, you run through the Medicaid experience and a comparison on price increases and you use the drug price increase of 138 percent between 1982 and 1992 compared to the growth of all consumer goods and services and CPI is something that may or may not be useful as a yardstick, but certainly people can react to the 138 percent increase versus 45 percent increase.

Do you have any comparisons against those costs narrowly within the health care industry? Do you have a medical price index comparison or something that would be a little more apples to apples?

Mr. VLADECK. Yes, sir, I do. Using 1982 as a base compared to 1992, CPI is up about 40 percent over that period. Let me restate this in terms of annual average rates.

The CPI went up between 4 and 5 percent on average in that period. Medical prices in total went up between 7 and 8 percent on average. Drug prices went up 8 to 10 percent on average. So that even compared to medical prices only, the medical component of the Consumer Price Index, prescription drug prices were growing 25 to 30 percent faster than medical prices.

Mr. THOMAS. During the same period, 138 percent—if it is a 10-year period—that would be a 13.8 percent growth average to reach the 138 percent growth. Between 8 and 10 percent, so it would be 80—

Mr. VLADECK. It compounds pretty fast; 10 and 11 percent is probably closer than 8 to 10 percent.

Mr. THOMAS. Rather than 8 to 10 percent, it would be 7 to 8 percent.

Mr. VLADECK. It is 50 percent faster on average.

Mr. THOMAS. On page 4, you talk about the drug utilization review and the program requires all States to assure that prescrip-

tions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

When you say that the program requires all States to assure, has there been some uniformity in the structure to produce that outcome. Is there enormous diversity? What is the cost to do that?

Mr. VLADECK. Mr. Thomas, the answer is that there is a basic uniformity of process in that every State has established a Drug Utilization Review Board and we have provided for guidance and informational purposes only a set of criteria and a set of suggested utilization screens to all the States.

I would say in general there is some variation from State to State both because practice patterns differ and because particular problems that have been identified are greater in some States than in others. So there is a fair amount of variation within the general framework.

In terms of the cost of administering drug utilization revenue, I don't have a number for you. I can tell you that like most such systems, it appears that merely by helping to flag truly abusive patterns of prescribing, you would pay for that enterprise many times over.

Mr. THOMAS. I understand that possibly, but as we get into decisions that are going to be very difficult ones both in terms of what is going to be available in very tight budget times and what, in a relative, comparative way, might be more useful, we are going to have to get more specific especially if folks are going to be advocating taking this and moving it up to Medicare and eventually moving it beyond.

I am concerned about the way in which the regulatory programs monitor and claim savings versus other ways to do it, and there may be cheaper ways, especially if we work in concert with the other areas of the law dealing with the patent process, the time available following government's approval process to industry to try to recoup research and development costs.

It is difficult if you don't have a yardstick to compare. It may be meritorious, but I would like to know how much meritorious costs.

Mr. VLADECK. We have a couple of formal demonstrations in process in two States and we have a broader evaluation contract that I think will go out in the next several months. So in the near future we should be able to give you real quantification of some of the effects of these activities.

Mr. THOMAS. On page 7, you talk about the President's budget proposal to permit States to establish formularies to give States more flexibility in administering their prescription drug programs.

I thought part of the OBRA 1990 agreement was that if you are going to set up the structure that you are going to allow Medicaid patients to have access. The manufacturer rebates tradeoff was for access. Is there any conflict in your mind in terms of now allowing States to set up restrictive structures which may or may not allow folks to get particular types of medicines by virtue of a State decision, maybe even establishing a two-tier or second-class structure for Medicaid people based upon the restrictive requirements that States may put in place?

Mr. VLADECK. There are several pieces to that question. I think you will find that many of the providers we identify as providing

the highest quality of medical care use identifiable formularies in their systems. Their physicians and their pharmacists believe it is a better way to maintain quality and appropriate prescribing behavior. So that many of the better HMOs and teaching hospitals have identified formularies, for example. It is a change from OBRA 1990.

There is a strong feeling on the part of many States and on the part of the pharmacy community that the use of formularies is a beneficial thing to do, not only in economic terms, but in quality terms as well. The real issue is how to implement State-by-State formularies without jeopardizing the access of Medicaid beneficiaries to needed drugs.

The language that is in the House reconciliation package has rather extensive safeguards in terms of trying to address the issue of protection of beneficiaries in the creation of such formularies. While I am not sure about the language, I think you can find ways to make sure they don't become an excuse for cutting off drugs from the people.

Mr. THOMAS. I think the best way to guarantee that is to develop an experiential factual base from common material provided by all so that when the decision is made, it is made upon a clear knowledge base of preference either in terms of procedural treatment or comparative costs or some other kind of clearly objective criteria rather than a political decision or pure budgetary costs, because that may not take into consideration all of the factors that need to be looked at.

It concerns me that we are talking about establishing controlling mechanisms before we have established an informational clearinghouse and a common structure for collecting information that would allow us to make decisions from a knowledge base rather than a single State's experience or a lot of the anecdotal comments that will be driving some of the decisions.

Mr. VLADECK. I think if formularies are to be permitted on a State-by-State basis, we have to assure that there is an appropriate database on which decisions can be made.

Mr. THOMAS. Don't you think that some of those decisions maybe could have been made already or could have been made now because they are so fundamental to any kind of health care reform that to hold off on those kinds of decisions will mean when we finally get to health care reform, we will be doing it more in the dark than we should have been?

Mr. VLADECK. If you are suggesting that we might want to move ahead in a number of areas on a variety of data issues that we could use regardless of the shape that health care reform takes, I would agree—

Mr. THOMAS. Common collection structure, fight out what it is that people should be reporting to that we can have a common basis?

Mr. VLADECK. We have been giving a lot of thought to the generic issue and I think you will be hearing from us relatively soon about things that might be done in terms of generic information collection regardless of the shape of health care reform that we ought to move on quickly—

Mr. THOMAS. The longer we wait, the greater opportunity I would think to move on agreed-upon almost prestructural changes that will provide us with a common information base over which we can make decisions.

Mr. VLADECK. There is no reason not to begin moving on the data now, however long the rest takes.

Mr. THOMAS. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. In a way, it is easy to choose up sides on the issue of how we handle pricing. Let me just ask you, the thesis in your testimony is that Medicaid provides some useful experience as we look at overall health reform and prescription drugs. So tell me the basic conceptual difference between the system we now have relating to pricing of drugs under Medicaid and proposals that would control the prices more directly?

What is the conceptual difference?

Mr. VLADECK. I think the conceptual difference, sir, is that even though the rebate percentages in the Medicaid program are specified in law, I would distinguish between a ratesetting process and negotiation that in this instance was carried out with the Congress, rather than with the States directly, about the size of a rebate tied to some market price.

In a sense, I think what the rebate program, conceptually, is trying to do is to say, "Look, there is a very complicated market in the wholesale and retail sectors for pharmaceuticals." We, through Medicaid and the public health service and the Veterans Administration are very big buyers in these markets.

We ought to be able to use our negotiating leverage to extract a comparatively good price relative to this for the market. I am sure there will be a thousand econometric studies that determine whether that price is better or inferior to a price you could get through some kind of formal ratesetting mechanism, but I think they are very, very different and it has in part to do I think with the notion of whether you are going to have a single pricing structure nationally for these products or whether particular buyers like government programs are going to try to get a better deal comparatively than the average market.

That is the conceptual part of it.

Mr. LEVIN. I am not sure I quite understand what we are going to get into with a reform structure where you have large units which have the power to negotiate rebates with manufacturers of drugs. So potentially within a State you could have one, two, or three large purchasing units.

So then unlike now where negotiating on rebates is done through Medicaid, you would have huge numbers of units competing with each other, some with the States and some outside them. Thus, it wouldn't make much sense, I think, would it, to have a different price in Illinois than in Ohio?

So trying to get at the conceptual difference between the Medicaid experience and a more direct price mechanism, it seems to me that the conceptual difference has to be something other than the number of units. So it seems to me that the conceptual difference comes down to, as I understand the Medicaid experience now, essentially you have the drug manufacturers setting an initial price,

and then a series of rebates to make sure that the purchasing unit—in this case Medicaid—gets something close to the average price being charged by the manufacturer, with an inflation factor set thereafter. Is that more or less it?

Mr. VLADECK. No. I think the theory is—and again the evaluations are just beginning, but the initial numbers are promising—that there is a market price out there and that because Medicaid is a big buyer, we are getting through the rebates essentially a discount from market both through the rebates and through the additional rebates for particular drugs whose prices are increasing more quickly.

Mr. LEVIN. There is some inflation control. So essentially it seems to me that what is being done within the present structure is letting the market set an initial price, but with a system to make sure that Medicaid gets the benefit of that price and then in addition to that you limit the increases annually or periodically; right?

Mr. VLADECK. Quarterly.

Mr. LEVIN. So the conceptual difference really is whether the initial price of a drug should be set by the market or by some kind of a control mechanism. So in a word, if the market works initially, then the system will work. If it doesn't, if there isn't true competition in the initial price setting, then the averaging mechanisms and the inflation control won't be enough.

So we really have to make a determination whether the market is working adequately enough so that when drugs are placed on the market and a price set that there is true competition; because otherwise, the inducement is to set your price high because the averaging will be affected by that and the inflation factor won't be enough.

So if you have a system where the focus is on averaging and an annual inflation factor, if the market doesn't work, there is an inducement to set the price higher. Isn't that—

Mr. VLADECK. Let me just say that I think that concept is right, but the issue is that I will be damned if I know what the right price is for any given pharmaceutical, let alone the whole array of ones we buy. But I can say with some degree of intellectual confidence that whatever the market price might be, I am a real big buyer.

I am expending the public's funds. I want the best price in this market that has a lot of price differentiation.

Chairman STARK. But you don't get it in the market, just from the manufacturers. If Sandy and I both make a drug and I sell it for \$45 and he sells it for \$5, you have to pay me \$45 and you have to pay him \$4.50. You don't have a system where you must buy it from him a lot cheaper.

Mr. VLADECK. If your drugs are identical, and the FDA tells me your drugs are identical and one is a generic then I do have an upper limit at 150 percent—

Chairman STARK. Assuming that they are the same use and somewhat different. There is no competition between manufacturers. It is just if I happen to sell it to some HMO at a lower price, you get it from me a little less, but you don't get it from him.

Mr. VLADECK. I agree the drug prices are probably too high, but that doesn't mean that I know what they ought to be.

Chairman STARK. Lower.

Mr. LEVIN. The quarterly rebates are a percentage of the average manufacturers price, so essentially what you are saying is if we go into a reform structure and you have a much smaller number of larger units, which is one way to describe one approach to reform, I take it then that the real issue here is whether there is enough competition so that a rebate system works, because if it doesn't then the price is set, the rebate and the inflation factor won't be adequate.

So your assumption has to be that there is true competition in drug pricing today it seems to me; that there is a real market when it comes to prescription drugs.

Mr. VLADECK. No. I think that is not entirely correct. I think at the conceptual level you may be right. My assumption has to be that given the other mechanisms available to me at the moment, I don't have a whole lot of confidence in my ability to do price setting for pharmaceutical drugs the way I do for hospital services or physician services or for home health services or whatever.

I think the problem is significantly more complex, so in an imperfect world choosing a second best, at the moment I think I am doing OK on a rebate system and I don't yet know enough about what a real price control system would look like to be confident about how I would do under that.

Mr. LEVIN. But you are not confident there is a real market?

Mr. VLADECK. I certainly wouldn't claim that there is, no.

Mr. LEVIN. So what you are really saying is that it is not the existence of a market, but the existence of complexity that leads you to adopt a rebate and review system rather than a pricing setting mechanism?

Mr. VLADECK. That is right. I think that is fair enough. We don't know enough at the moment to run a pharmaceutical pricing system the way we price other kinds of services. That is not a conceptual impossibility, but I think at this time it would be very difficult practically.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman and welcome, gentlemen.

Mr. Vladeck, at least three witnesses today will mention the benefits of Medicare beneficiaries obtaining drug benefit through existing managed care programs. What is HCFA doing to encourage or provide incentives to seniors to use managed care?

Mr. VLADECK. Mrs. Johnson, there is a whole set of issues associated with the Medicare managed care programs, the most important of which at the moment have to do with the inadequacies of our payment methodology for risk contracting HMOs.

The APPC is a very crude instrument in a variety of ways. There is a lot of unhappiness with it on the part of the HMO community as a result of which we are not getting the kind of participation in the Medicare risk business that we would like to see. So we are embarking on an extensive research and demonstration project on payment methodologies for HMOs under Medicare that we hope will find a mechanism which will encourage substantially more HMO participation and involvement.

Mrs. JOHNSON. HMOs are not the only form of managed care nor are they in certain instances the most desirable form of managed care. Are you doing anything else to expand Medicare select or override the 50/50 requirement or remove any other impediments to the development of managed care and Medicare?

I think it is significant that 95 percent of Americans are in some kind of managed system ranging from copays to staff model HMOs but 95 percent of seniors are not in any kind of managed system and in 1991 public health care costs grew 13 percent and private sector health care costs grew 7 percent according to your chart.

I have the page and I will get it to you because what it suggests to me is that some of the cost containment efforts in the private sector are beginning to gather steam and focus and appear in statistics, and it disturbs me that the public sector is so far behind in managing its folks more effectively in health care. Your success in the drug area in eliminating duplication and really improving quality at the same time you are controlling costs is sort of a microcosm of the need for those kinds of approaches in a larger program so I am interested that you are beginning to focus on these things in Medicare.

Are you making any move to extend the Medicare select demonstration projects that I understand expire soon?

Mr. VLADECK. We have supported the extension of that demonstration until it has been in place long enough for us to learn something from it.

Mrs. JOHNSON. Are you pushing for it?

Mr. VLADECK. We are supporting extension of the demonstration. We are not supporting expansion in more States. We have more demonstrations going on now than we can adequately monitor and measure. We are going to pay more attention to what is actually happening in those demonstration projects.

Mrs. JOHNSON. In my State of Connecticut, one of the things I hear a lot about, and every State is up against it in trying to control Medicaid costs and most of Medicaid is nursing home related and a significant factor is prescription drugs. Over and over again, I get reports both anecdotal and from State legislative sources of the enormous waste of prescription drugs in the nursing home system, much of it required by our regulations.

Have you looked into that at all?

Mr. VLADECK. I don't know what you mean by required waste in our regulations. If you could provide us with more specifics—

Mrs. JOHNSON. One example is not being able to save what is left over of a prescription even if the pills are individually packaged, and use it another time rather ordering more for another patient, that kind of thing.

Mr. VLADECK. There is a general prohibition in all health care facilities on giving one patient medication that has been prescribed for another.

Mrs. JOHNSON. Don't you think it is time to look at that since there is evidence of a lot of waste behind those regulations and find a system that would allow a facility to use its resources more effectively?

Mr. VLADECK. I think there are ways to minimize the waste that comes from the way you manage nursing home pharmacies.

We would be happy to look further at specific instances, but I think there are ways of minimizing those problems without undermining the basic principle of not giving someone else someone else's prescription.

Mrs. JOHNSON. It is worth a lot of attention if the information I receive has any truth to it at all.

We look forward to working with you on that.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. I will be reading your testimony very carefully and we look forward to working with the administration in developing a prescription drug benefit package that is reasonable and will encourage more cost effective care in this country.

I think it is absolutely essential that there be part of a national health benefit package to include prescription drugs as a way of minimizing the health care costs of this country and I look forward to working with you in developing that program.

Mr. VLADECK. Thank you. I appreciate that.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

The purpose of this hearing as I understand it is to talk about the advisability of including in a basic benefit health package prescription drug coverage, and I am wondering if you could offer us an opinion based on your knowledge of the Medicaid program and its coverage of drug benefits, what kind of costs this would add to a basic benefits package?

If you left it out, would it decrease the price? If you put it in does it increase, does it make any difference?

Mr. VLADECK. That is very hard to do in such general terms because the cost of a drug benefit package is so sensitive to two things. One is how you design it in terms of copayments, in terms of deductibles, in terms of any limitations on coverage, in terms of caps on out-of-pocket expenditures.

The second is for the nonelderly, non-Medicaid, private insurance does have very extensive drug coverage on average at the moment. So the question is what is between the gross cost of the benefits and the net cost given existing patterns of coverage?

There is an issue in making the estimates for the elderly as well as the nonelderly. It is a little tricky for the elderly because we don't know that much about the kind of drug programs Medicare beneficiaries have. The numbers that have been talked about in terms of a Medicare drug benefit range from \$15 to \$20 billion depending on how generous a benefit it is, how it is structured and the extent to which it replaces existing coverage among the elderly rather than wrapping around it.

I think you can come up with numbers based on what you want to do in terms of the benefit.

Mr. MCCRERY. Let me jump to just the Medicare program in isolation. If you were to simply expand the Medicare program to include prescription drugs, how much is that going to increase the cost to the government? If you use the Medicaid model for drug utilization review and all that—

Mr. VLADECK. It depends. If you used 20 percent coinsurance, a major financing question would be whether or not you had another

deductible. A major question would be whether you continue to be a secondary payer for those beneficiaries who have employment-based or other related coverage, or whether you increase the part B premium for 25 or 27 percent of the expected costs.

There are a lot of variables in the design. Medicare outlays are in the range now of \$160 billion this year. I think the net increase in government outlays would almost certainly be less than the amount at which the program is inflating each year just by ordinary baseline growth. It would be in the range of less than \$20 billion. It could be a lot less depending on how large the deductible is, how you manage the coinsurance, et cetera.

Mr. MCCRERY. You might add \$20 billion—

Mr. VLADECK. I think that would be the outside limit for a very generously defined benefit.

Mr. MCCRERY. Would you have to set up a drug utilization review system for your Medicare program?

Mr. VLADECK. You could build it on the existing standards of the Medicaid program, but you would need to build that into the system.

Yes, sir.

Mr. MCCRERY. How much would that cost?

Mr. VLADECK. As a percent of the benefit, it would be several zeros to the right of the decimal point. We are talking in the range of several million dollars a year to set up and administer a separate utilization review as part of an automated system.

Mr. MCCRERY. Several million dollars?

Mr. VLADECK. Yes, sir.

Mr. MCCRERY. Less than a \$100 million?

Mr. VLADECK. Yes. It is expensive to administer because of the number of claims, but most of the expense is the actual processing of individual claims, electronic submission of bills, and record keeping. The utilization review is a small fraction of the total expenditures.

Mr. MCCRERY. How much does your Drug Utilization Review program in the Medicaid program cost?

Mr. VLADECK. We will try to get exact numbers, but it is significantly under 1 percent of the total benefit. It is a tiny fraction of the total Medicaid administrative costs, States and Federal combined. It is not an expensive thing to do.

[The information follows:]

Although specific data are not available, we estimate that the Medicaid drug utilization review program will cost about \$15 million. This is based on a projected average cost of \$300,000 per State (\$50,000 for prospective DUR and \$250,000 for retrospective DUR). Costs will vary based on the size of the States' Medicaid populations and on whether the State had previous experience in DUR when it became a requirement on January 1, 1993. Eighteen States had established retrospective DUR programs before this date. Because DUR has been required only since the beginning of this year, hard data will not be available for some time.

Mr. MCCRERY. Well, Mr. Chairman, I hope we will thoroughly explore this question of what this is going to cost to the Federal Government and the taxpayers before we dive into expansion of Medicare, knowing the universe of people that are going to be served by this new benefit and knowing that their utilization is considerably higher than the Medicaid programs universe of users.

I am concerned that your figures are perhaps low, and I hope we get some more testimony on that.

Mr. VLADECK. When we have a proposal we will have details.

Chairman STARK. Mr. Brewster.

Mr. BREWSTER. Thank you, Mr. Chairman.

Chairman Stark noted a moment ago that there are lots of countries around the world where medications are sold much cheaper than in the United States. Are you aware of any other product manufactured in the United States that is sold at half the price or less than half the price in other parts of the world?

Mr. VLADECK. I am not.

Mr. BREWSTER. You are not aware of anything else that is sold that way?

Mr. VLADECK. The fact that I am not aware doesn't mean it is not there.

Mr. BREWSTER. You said you as a purchaser would want to get the best price. Would that not also mean that your provider would have to have the best price to be able to provide you with the best price?

Mr. VLADECK. Absolutely. It means nothing to talk about one's market power in purchasing drugs if the retailers from whom the beneficiaries get it can't benefit from use of that market power.

Mr. BREWSTER. Are you also worried that within the industry there are discussions about pricing policy and even some who may be larger purchasers that others may have a price that is four times as high as someone else?

Mr. VLADECK. One of the things I was walking around earlier was that the complexity of the entire pricing structure in the pharmaceutical industry is really quite remarkable to me, and so at the current state of information we have, we are groping to a certain degree in an area of very, very high uncertainty.

As I think Mr. Levin suggested, if you do begin to undertake health care reform in a way that aggregates more market power on the purchaser side, you may be able to get a somewhat more orderly homogeneous market in that regard.

Mr. BREWSTER. But it would stand to reason that if you are in business and you have to raise x number of dollars, if one guy gets a price that is extremely low there will be cost shifting to someone else to provide the dollars that are necessary for research, and other things a company has to do. They have to make a profit.

Mr. VLADECK. In general, that is true. I do think that when a producer moves from a market in which everyone will pay whatever he asks to a market in which everybody but one guy pays whatever he asks, if he has been doing quite well before then, there may be a variety of reasons including political reasons why he won't shift the entire difference to the others.

Mr. BREWSTER. I notice you have some reference in here to a formulary system. Do you think that Medicaid is currently paying for some things that are not medically necessary?

Mr. VLADECK. No system is perfect. I am sure there is payment for medically unnecessary—

Mr. BREWSTER. Do you plan to address that?

Mr. VLADECK. There are several ways of addressing it. One is to look at the possibility of providing States some authority to move

to particular kinds of formularies under certain mechanisms and see if they can identify those kinds of things. We have put these data systems in place for utilization review, but the better your data system gets, the more work you have to do in looking at the data we now have and learning what that tells us about patterns of use.

Mr. BREWSTER. On the State formulary system, would you primarily look at categories of drugs, approve everything within a particular category, or limit the number of categories or select one or two items from a category?

Mr. VLADECK. My hope, and I hope we get legislation that permits it, would be to permit States to focus particularly on real questions about indications, usefulness, or the ratio of price for other pharmaceuticals that are therapeutically believed to be as good or better.

Mr. BREWSTER. Say in antibiotics you wouldn't just approve tetracycline and not approve cephalosporins; you would approve the whole category?

Mr. VLADECK. I think the most effective use of formularies at a State level would be as a way of targeting particular problem drugs and prescribing patterns rather than trying to overly narrow availability. Some of the processes would try to produce that result.

Mr. BREWSTER. I am pleased to see you moving on electronic DUR. I personally feel that drug utilization review is a cost saving as opposed to a costly item. In many cases utilization review prevents misapplication, misutilization of pharmaceuticals.

When we talk about going with a Medicare program, I personally feel that many senior citizens misuse medications. Do you feel the pharmacist has a role as a consultant in this important part as well as Medicare and Medicaid as we move to the future?

Mr. VLADECK. The 1990 amendments require pharmacists' counseling of Medicaid patients. Many States responded by implementing a broader requirement for pharmacist counseling of all patients. I think part of what is happening as a result of these discussions over the last several years is that we are beginning to look more frontally about the very important role of the retail pharmacist in this entire system. I think the net effect has been salutary and we can continue to move in that direction.

Mr. BREWSTER. With some responsibility, I think the pharmacist can be a gatekeeper provided he provides the proper prices to deal with your problem.

Mr. VLADECK. I think the issue of prices for pharmacist services is a lot less complex and can be addressed more easily than the issue of the acquisition costs for the pharmaceuticals.

Mr. BREWSTER. I appreciate your answers.

Chairman STARK. I wanted to go back over the rebate system a bit to make sure that I understand it. Two situations. If a drug manufacturer has a list of drugs A through Z, and signs the rebate agreement, then Medicaid is obligated to pay for any of those products A through Z; is that not correct?

Mr. VLADECK. If prescribed—

Chairman STARK. So even if they make goose grease with food coloring in it and it was prescribed by a dermatologist to color your hair, you would have to pay for it?

Mr. VLADECK. I don't think we would consider that a medical use; depends on whose hair.

Chairman STARK. You suggested to Mr. Brewster that medical necessity was not something that you had a means of dealing with.

Mr. VLADECK. I didn't mean to suggest that. It is clearly a focus of drug utilization review. I was suggesting we are in the early stages of implementing—

Chairman STARK. Suppose you decide something is not medically necessary. How do you get it off the list without a formulary?

Mr. VLADECK. At the moment, the DUR process is a case-by-case kind of process. If we see physician X prescribing what is not medically necessary, the first thing we do is send him a letter. The second thing we do is send a representative.

Chairman STARK. With 9,000 manufacturers manufacturing 3,000 drugs, arguably a few guys are packaging the same goose grease, but calling it something else?

Mr. VLADECK. Undoubtedly.

Chairman STARK. The part of this rebate scheme that was dreamed up by the pharmaceutical manufacturers, certainly not on your watch, I can understand that the current administration wouldn't have been party to anything like this, is the other side. So the guy signs up and all his products good or bad are on the list. Even if somebody else makes a product for less that effectively does the same thing, two kinds of ulcer, antigas stuff so one is Gelusil and the other is Di-Gel or Mylanta; right?

So one guy sells it for half—

Mr. THOMAS. Are we going to plug the other drugs now?

Chairman STARK. You have to pay the other guy twice as much because he signed the agreement. Let's take the case of a very useful new drug that costs like 25 hundred bucks for heart attack and people want to use it. They didn't sign a rebate. It is medically necessary, it is effective, and you have to pay whatever they charge because they didn't sign the rebate agreement.

Mr. VLADECK. In that example, that is an inpatient drug so that is another problem.

Chairman STARK. Say it is an outpatient drug.

Mr. VLADECK. When you have a single manufacturer—

Chairman STARK. You pay retail.

Mr. VLADECK. Yes.

Chairman STARK. This sounds to me as if I were making drugs, and that sounds more profitable all the time, that this is a win-win situation. There is another issue that the ban on the formulary—

Mr. VLADECK. I have been corrected by my staff. If you don't have a rebate agreement with us for a single new drug, Medicaid won't pay for it at all.

Chairman STARK. What if it isn't a new drug but just a drug?

Mr. VLADECK. We won't pay for it.

Chairman STARK. If there isn't a rebate agreement, you can't buy it?

Mr. VLADECK. That is correct.

Chairman STARK. So you have to take the guy's entire line or nothing?

Mr. VLADECK. That is the way it is.

Chairman STARK. Under the recent budget bill, the Senate in their wisdom and the Energy and Commerce Committee in their wisdom have repealed the ban on formularies. I trust that the administration supports that vigorously?

Mr. VLADECK. One might argue about the adverb, but we certainly support it.

Chairman STARK. As does the Chair. I am happy to hear that. There has been some question about—well, I guess if we finish up and allow the formularies to come back, we will be back in business and doing the right thing again.

Mr. Thomas.

Mr. THOMAS. How do you determine what the rebate should be?

Mr. VLADECK. That is a very good question. The rebate is specified in the statute. There is a very complex formula and frankly, sir, I think the statutory provisions reflect a negotiated agreement in the process as I understand it that produced these amendments. Basically, what you are talking about in this instance was a quadripartite negotiation between the manufacturers and their representatives, the States and the Federal Government—

Mr. THOMAS. Nevertheless CBO estimated how much—

Mr. VLADECK. Well, because the agreement produced a formula that permits you to actually put a number on that rebate.

Mr. THOMAS. I understand the rebate coming in now is twice as high as CBO estimated it was going to be.

Mr. VLADECK. That is the gross proceeds, not the percentage rebate. That has to do with the volume of prescriptions which has to do with the number of beneficiaries and what kind of drugs they are receiving, as well as the way the rebate process works.

Mr. THOMAS. There is an inflation factor in the formula?

Mr. VLADECK. There is the separate upper limit on particular drugs that provide for additional rebates if their prices go up faster than overall inflation. That may be producing some of the additional rebates.

Mr. THOMAS. In terms of the cost of drugs, I know it is a very small segment of the total drug market if you look at all the thousands of drugs you are discussing, the biotechnology therapeutic drugs. I have a list showing the cost in the United States versus the cost in European countries, and Japan. It is on five of them, which are 75-percent of the biotechnology therapeutic drug sales, one controlled by Medicare, a essential human growth hormone, alpha-interferon and others.

[The chart referred to follows:]

Global Price Comparison of Biotechnology Therapeutics

	US	Germany	UK	France	Spain	Italy	Switzerland	Average European	Canada	Japan	% Difference US/Europe	% Difference US/Canada	% Difference US/Japan
Human Growth Hormone (1 international unit)	\$14.00	\$26.00	\$13.00	-	\$21.00	\$21.00	\$27.00	\$22.00	\$27.00	\$53.00	-36%	-48%	-74%
G-CSF (300 mg vial)	\$112.00	\$122.00	\$104.00	\$143.00	\$93.00	\$88.00	\$112.00	\$122.00	\$122.00	\$378.00	-8%	-8%	-70%
EPO (4,000 unit vial)	\$40.00	\$60.00	\$54.00	\$59.00	\$52.00	\$50.00	-	\$57.00	\$43.00	\$99.00	-30%	-7%	-60%
Ceredase (per unit)	\$3.50	\$3.50	\$3.50	\$3.50	\$3.50	\$3.50	\$3.50	\$3.50	\$3.50	\$3.50	0%	0%	0%
Alpha Interferon (10 ⁶ units)	\$8.75	-	-	-	-	-	-	\$9.00	\$8.75	\$25.00	9%	0%	-65%

These five drugs represent over 75% of 1992 biotechnology therapeutic drug sales in the U.S.

NOTE: Prices are at manufacturer, or wholesale, level, but are consistent for each product.

The "mark-up" to consumers varies widely and the manufacturer has no control over the final price.

Interestingly enough, there are significant differences between the United States, Europe and Japan and on a percentage basis, significantly cheaper generally and specifically in the United States. This is at least helpful to me because we are talking basically about the cutting edge growth market area and that for some reason they may be getting the old stuff out the back door on an ongoing mix—it-up basis, but some of the cutting edge stuff they are paying significantly more for than are we.

For example, on the EPO, the United States is \$40, a negotiated price. Europe averages \$57; Japan averages \$99. So in some areas, we may be doing at least as well or better than those foreign purchasers.

When you were talking about the rebate structure under the original Medicaid legislation, why are pharmacists held harmless in terms of cost?

Mr. VLADECK. I am not sure I understand that question.

Mr. THOMAS. Were they a passthrough on costs?

Mr. VLADECK. Basically the Medicaid pricing system has always been a two-piece system in which the dispensing fee, the term generally used, is treated separately from the pharmacist direct cost for acquisition of the drug.

Mr. THOMAS. How are you dealing with that portion of the cost? Is there a control or a—

Mr. VLADECK. States generally set that pretty much unilaterally although they hear from pharmacists from time to time about the level. We have had a study in process to look at the adequacy of those fees given the expanded expectations on pharmacists under the new law and we owe you a report in the next few months on the findings.

Mr. THOMAS. In terms of formularies, it is nice to see that everyone is in favor of them, but I will go back to my original statement about basing them on a shared agreed-upon knowledge base. For example, I assume that as we move to formulary requirements, teaching hospitals, hospitals in general under Medicaid, Medicare, we are using a standard formula, aren't we, a standard structure that they aren't different for one than they are for others?

Mr. VLADECK. I think every institution that has a formula has its own.

Mr. THOMAS. But is the structure the same in terms of implementing it?

Mr. VLADECK. I don't know exactly what you mean by a structure. I do know that every institutional formulary committee has a certain professional and institutional pride and autonomy and nobody wants to just copy someone else's formulary. Most are efforts to think of every—

Mr. THOMAS. If you want to wanted to cope someone else's, I assume it would be based upon a knowledge base of applicability, price and objective factors?

Mr. VLADECK. Many of the databases are common, but no two formularies with which I am familiar are identical. Different physicians and pharmacists and pharmacologists looking at the same data will come to different conclusions.

Mr. THOMAS. Is this going to be a problem?

Mr. VLADECK. I don't think so. I think it is one of those areas that exemplifies the extent to which we can have a wide variety of data about all kinds of medical issues and different interventions and outcomes, then when individual practitioners and their organizations at the community level decide what they want to do with that data.

Mr. THOMAS. But if the government is paying for it and they are not common, you run into a real political problem about who gets what and why someone gets better than another.

Mr. VLADECK. As we evolve better experience, we will have to think about whether a problem exists and if so we will have to deal with it.

Mr. THOMAS. Common database and generally acceptable structure of a launching pad for formularies would be helpful in that regard.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

I enjoyed the exchange relating to developing a system dealing with medical necessity proper utilization, and for the proper pricing to ensure a fair return to manufacturers and to pharmacists without cost shifting from one segment, from government to the private sector.

I want to make sure that as we expand coverage for prescription drugs we look at ways of dealing with those very difficult issues to make sure we have the most cost-effective system.

Talking a little broader for a moment, I know people in my community, elderly people that have to make difficult judgments and sometimes they don't buy the prescription drugs they need because they don't have the money and it is not covered under the Medicare program. They may well come into the system with much more costly care as a result of not taking the drugs that they need to take.

I would hope that as you go through these cost analyses that you look at the fact that in some cases we are going to be saving money for the Federal taxpayer by providing less costly care for a pharmaceutical than we would if the person needed more costly intervention through hospital physician care. I haven't heard that talked about much.

I hope that you are committed as you do these analyses to look at ways in which expanding coverage will in some cases save us money.

Mr. VLADECK. Thank you.

I wish we had better data to make that case more systematically to skeptical actuaries inside government and without. Given some of our experience with home health and with hospice, this is something we ought to do just because we ought to do it, because Medicare beneficiaries ought not be denied drugs they need for their health because of economic reasons.

We will try to come up with the most realistic, reliable, hard net cost estimates we can in which savings from hospitalization clearly ought to be part of it. This is something we ought to do because we ought to do it—

Mr. CARDIN. I agree; we should do it because it is the right policy. The difficulty is to get it enacted, we need to comply with rea-

sonable budget scoring rules. A lot of preventive health services that we have talked about get scored about the savings that are attendant to that type of proper care.

I would hope that you will be sensitive to the fact that we are paying the cost today in our health care system for not providing certain coverage. As we look to providing what should be the comprehensive benefit package that Americans are going to be entitled to receive, that we take a look at what we will be saving in unnecessary health care expenses by providing what we should have been providing all along.

Mr. VLADECK. Let me promise you that as we move forward with our proposal we will do everything we can to make sure OMB and CBO get the best cost effectiveness arguments on this benefit and the best cost effectiveness data we can get to them.

Mr. CARDIN. I know that is difficult, but the information is there. We know people who are incurring costs today, Medicare recipients, for medical treatment that would not have been necessary if they used alternative treatment ahead of time including prescription drugs.

It seems to me we can do a better job than we have done in the past in making the case that there will be cost savings as a result of expanding these benefits.

Mr. VLADECK. We will do the best we can.

Chairman STARK. If there are no other questions, thank you Mr. Secretary.

Mr. VLADECK. Thank you, Mr. Chairman.

Chairman STARK. Nice to have you with us.

Mr. VLADECK. See you again before long.

Chairman STARK. Our next witness representing the Office of Technology Assessment is Dr. Judith Wagner, senior associate; accompanied by Dr. Michael Gluck, who is a senior analyst.

Welcome to the committee. Why don't you proceed in any manner that you are comfortable.

STATEMENT OF JUDITH L. WAGNER, PH.D., SENIOR ASSOCIATE, HEALTH PROGRAM, OFFICE OF TECHNOLOGY ASSESSMENT, ACCOMPANIED BY MICHAEL E. GLUCK, PH.D., SENIOR ANALYST

Ms. WAGNER. With your permission, we will submit our written statement for the record.

My remarks today build largely on the work OTA did at the request of the House Energy and Commerce Committee on the economics of pharmaceutical research and development. That study, which we published in February, examined the costs and risks of pharmaceutical R&D and the financial returns that companies get from engaging in R&D.

As always, we stand ready to brief the members of this committee or their staffs at any time on the subject of that report.

Providing the elderly with a prescription drug benefit will solve some important problems of access for this vulnerable population. We know that the elderly use a disproportionately large share of prescription drugs and that at least one half of all elderly people have no insurance benefits covering prescription drugs.

It is telling, I think, that 10 States have gone ahead on their own and established State Pharmaceutical Assistance programs that extend pharmaceutical benefits to low-income seniors. Together these States spend about \$500 million a year out of State-only money to provide these benefits and they cover almost a million people. So the need is there and at least some States have moved in to meet the need.

That said, it is important to recognize that any attempt to build a universal medical insurance benefit for prescription drugs will have to come to grips with realities about how the market works and will have to consider the pros and cons of keeping prescription drug costs from escalating.

Despite the recent publicity about pharmaceutical prices and price control, the truth is that prescription drugs are the last remaining area of health care whose prices and utilization remain largely, not entirely, uncontrolled by third-party payers.

The market for prescription drugs has four attributes that will make any attempt to influence or constrain drug prices very difficult.

The first is the strong patent protection of new compounds that last typically 10 years or more after a drug is introduced on the market. Patent protection means pricing freedom. The intent of patent protection is to stimulate innovation, which it does very handily in the case of prescription drugs, but it also means that the owner of the patent has the right to charge whatever the market will bear.

In the case of prescription drugs, the market will bear quite a bit and that leads me to the second aspect of the market and that is the widespread availability or the widespreadness of insurance coverage for prescription drugs. This insurance coverage is not only widespread, it is improving in its quality and at least 70 percent of all Americans have prescription drug coverage.

Insurance of any kind makes consumers relatively insensitive to the prices of insured services and they become particularly price insensitive when they don't have the technical know-how to understand the therapeutic choices before them.

For almost all insurers, FDA approval to market a drug is a de facto coverage guideline. If it is an approved drug and prescribed by a physician, the insurer will pay for it.

The third aspect of the market is that prescribing physicians are profoundly ignorant of the prices of the drugs they order, even those they order frequently. We can only conclude that they have insufficient incentive or resources to find out what those prices are. Even if they did know, we are not sure whether or not they would consider price as well as quality in making prescribing decisions.

Fourth, the market for prescription drugs is easily segregated into submarkets, so companies can charge different prices to different kinds of buyers.

This practice, known as price discrimination, allows companies to price low when they have to with a price sensitive buyer to get business and to price high when they don't have to. The only good news about the market for prescription drugs is that once a drug is off patent, there is a strong system in place to get generic copies

of brand name drugs on to the market and the equivalence of these generic copies is verified by the FDA.

So at the end of the product's patent life, the opportunity for price competition is excellent. But taken together, these elements of the market mean that providing better insurance benefits to the elderly will reduce their price sensitivity even further, and without finding ways to make consumers and their prescribing physicians more sensitive to price in making prescribing choices, prices are likely to climb as a result.

As a final comment, I would like to stress that the problem is with the market for prescription drugs, not with the pharmaceutical industry. The industry is a dynamic competitive one which is responding appropriately to the signals in the market as it operates today. Those signals say to the industry, "Compete with one another by developing new products and market those products intensively, but don't compete vigorously on price because it won't pay."

The result is that we have an industry that spends a great deal on R&D, much of it competitive, and which provides a wide array of choice in almost every therapeutic category, but it provides these choices to a market that seems unable to translate their choices into lower prices.

With that, I will complete my prepared remarks and we are happy to answer any questions.

Mr. CARDIN [presiding]. Thank you.

We appreciate your statement.

[The prepared statement and attachments follow:]

STATEMENT OF JUDITH L. WAGNER, PH.D.,
AND MICHAEL E. GLUCK, PH.D.,
OFFICE OF TECHNOLOGY ASSESSMENT
U.S. CONGRESS
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE HOUSE COMMITTEE ON WAYS AND MEANS

Coat Containment and The Market for Prescription Drugs

June 22, 1993

Thank you, Mr. Chairman. We are here today to provide the Committee with information on problems in the market for prescription drugs and prospects for cost containment if a prescription drug benefit were legislated for Medicare beneficiaries. As you know, OTA recently completed a report, Pharmaceutical R&D: Costs, Risks, and Rewards. Our remarks today are based on research we conducted for that study, but they also draw on new things we have learned since the report was published in February of this year.

Why Worry about Prescription Drug Cost Containment?

The need to contain the costs of prescription drugs stems from 5 basic elements of the market for prescription drugs.

1. Strong Patent Protection--Each prescription drug product begins as a new molecular entity (NME), a new compound whose active ingredient is different from any previously tested in humans. This NME is typically protected by a patent covering the compound, its manufacturing process, or its use (sometimes all three). When the Food and Drug Administration (FDA) approves the compound for marketing in the United States, the patent protects it from copy for the duration of the patent. (The effective patent life is currently about 10 years.)

As long as it holds a patent on the compound, the originator company has the sole right not only to sell the drug but also to test and introduce "product line extensions," such as once-a-day forms. These product extensions are granted exclusive marketing rights for 3 years following their approval for marketing. Companies have timed their applications for approval to market once-a-day forms to coincide with the end of the compound's original period in order to extend the effective patent life of the compound.

Sometimes a new drug may not be protected by patent, either because the patent on the compound expired before its therapeutic value was recognized or because it cannot be patented, as in the case of some biotechnology drugs. If the drug is useful for a small enough population, the developing company can apply for orphan drug designation, which gives it 7 years of exclusive marketing upon approval by FDA.

Patents and other market exclusivities protect a compound from exact copy, but the protection from competition is by no means complete. Similar compounds with similar therapeutic effect, though having a different molecular structure, can be patented, developed and introduced by other companies. In many therapeutic categories, several different compounds are on the market, each with patent protection, all with very similar therapeutic effects. For example, currently there are three compounds on the market in a new class of cholesterol-lowering drugs (HMG-CoA Reductase inhibitors); a fourth is awaiting approval from FDA, and about 12 other compounds are in various stages of development (See Table 1). The first drug approved in the class--lovastatin (brand name Mevacor[®])--is often referred to as the pioneer; the compounds introduced to the market later are often called me-too's.

2. Widespread prescription drug insurance--Like all kinds of health insurance, prescription drug benefits protect consumers from uncontrollable and catastrophic expenses, but they also reduce the effective price of drugs to consumers. By reducing patients' out-of-pocket costs, health insurance makes them less sensitive to price than they would otherwise be.

It is not very well appreciated how much insurance coverage for prescription drugs improved in the United States in the 1980s. This improvement took two avenues that made the demand for prescription drugs even less sensitive to price than it was before. First, the percent of Americans with outpatient prescription drug benefits increased, albeit modestly, over the 1980s, from 67-69 percent in 1979 to between 70 and 74 percent in 1987, the latest year for which good data are available. (See Table 2).

Second, the extent to which people with outpatient prescription drug benefits were insulated from drug prices increased substantially over the 1980s. While 88 percent of all non-elderly people with outpatient drug benefits in 1977 had "major medical" plans with an overall annual deductible that had to be met before insurance would help pay for costs, by 1989, 30

percent had policies that required fixed copayments for prescription drugs (most frequently \$5 per prescription) without any deductible (See table 3). The insurance company picked up the rest of the bill regardless of the amount. The switch from overall deductibles to fixed copayments for prescription drugs means a richer insurance benefit structure for prescription drugs. A flat copayment means lower out-of-pocket prescription drug costs and little sensitivity about price.

The impact of these improvements shows up in insurance reimbursements. The percent of total outpatient prescription drug spending paid for by insurance increased from 28 to 44 percent between 1977 and 1987 (figure 1).

Most private health insurers have little power to restrict physicians' prescribing decisions. Private and public health insurers generally cover all prescription drugs the FDA has licensed for sale in the United States. Thus FDA approval is a *de facto* insurance coverage guideline. If the physician orders a specific drug, the insurer routinely pays its share of the cost. If the drug is under patent, the insurance company will end up paying whatever price the manufacturer charges (plus a wholesale and retail markup).

There are exceptions to this general rule of insurer passivity, which we will discuss a bit later. Despite the exceptions, the largest part of the market for outpatient drugs remains in insurance plans in which the insurer in effect has little say over what it will pay for or what price it will pay.

3. **Physician Ignorance of Drug Prices**--Although in surveys physicians say they do care about drug prices, they also routinely fail tests of their knowledge of drug prices. A recent survey of family practitioners, for example, found that the majority of responding physicians could not accurately identify the price range of 20 prescription drugs advertised in two primary care medical journals.¹

If most patients are insured, the physician has little reason to consider price as well as quality in picking among the sometimes many alternative compounds available to treat a condition. It is no wonder, then, that drug companies spend so much money on advertising and promotion to compete for market share. One major U.S. pharmaceutical company recently reported spending about 19 percent of its sales on marketing (advertising and promotion).² Emphasizing "product competition" over price competition is a rational strategy for companies when prescribing physicians are not very sensitive to price differences among similar compounds. If prescribing physicians will not be swayed by lower prices, but will be influenced by promotional information, it would be foolhardy for firms to set prices for their products much lower than those of their competitors.

4. **Ingrained Price Discrimination among Classes of Buyers**--Prescription drugs are sold through multiple distribution channels, and companies can charge different prices to different kinds of buyers. For example, they can sell direct to large hospital chains or HMOs and offer lower prices than they charge to wholesalers or retail pharmacies. As long as these different distribution channels are segregated from one another, and buying and selling across channels is infeasible, companies can tailor the price they charge to the conditions of demand in each sub-market. When companies can successfully segregate sub-markets from one another and charge different prices, they are engaging in a practice known to economists as price discrimination. Price discrimination increases profits by allowing the seller to determine separately the best price for each sub-market.

Price discrimination in pharmaceutical markets takes its most extreme form when companies offer expensive drugs at reduced charge or even free to people who cannot easily afford them because they are low income and have no insurance. Many pharmaceutical firms have developed such programs in recent years. Although these programs respond in a compassionate way to a real need, they also separate the market into two components--one with a very high price sensitivity (uninsured people) and one with very low price sensitivity (insured people). By offering these special prices or free programs, the companies may reduce public criticism of their pricing policies.

Price Sensitive Buyers Pay Lower Prices--For example, some large HMOs, particularly those with tight organizational control over their physicians' prescribing practices, have been able to turn this control into a countervailing market power that brings them lower prices for the drugs they

1 Miller, L.G., and A. Blum, "Physician Awareness of Prescription Drug Costs," *Journal of Family Practice*, January, 1992.

2 Eli Lilly and Company, Annual Reports, 1987, 1988, and 1989.

purchase. Probably the most important tool at their disposal is the restrictive formulary, a list of drug products that can be prescribed without special appeals or approvals. (Others must be specially requested.) The power to impose limitations on prescribing has given these HMOs purchasing clout with manufacturers and led manufacturers to offer sometimes substantial price discounts to some of these organizations. When there are several close substitutes in a therapeutic category, the HMO can use the formulary as a bargaining chip to exact price concessions from producers.

Hospitals also have an incentive to establish formularies for drugs administered to inpatients. In 1983, Medicare adopted a new "prospective payment system" that pays hospitals by admission, not for the services each patient receives. This system created incentives for hospitals to reduce both length of stay and the cost of services offered per stay, including drugs. The number of hospital pharmacies adopting formularies increased steadily in the mid-1980s. By 1989, 58 percent of hospitals had a well-controlled formulary.³

Discounts to price-sensitive buyers can be very creative. One drug company recently signed a deal with a large hospital purchasing group that gives the hospitals equity in the company's stock based on their purchases of the company's flagship drug.⁴ This kind of an arrangement not only gives an indirect price break but also encourages member hospitals to increase their use of the drug.

Figure 2 shows the distribution of pharmaceutical sales in the United States by trade channel. Notice that only a very small part of the market is in direct sales to staff-model HMOs, the kind of HMOs that typically can control their physicians' prescribing patterns. Although managed care is growing rapidly in the United States, to date, few such health insurance plans have put into place restrictive formularies or other effective means to influence prescribing patterns of their member physicians. So, the price-sensitive segment of the market, though growing, is still rather small.

Price-Sensitive Buyers Gain from Competition among Pioneers and Me-too Drugs--The success of some HMOs and hospitals in getting price concessions attests to the potential for price competition to lower the cost of drugs to patients and their insurers. The opportunity to negotiate lower prices for a drug depends on the availability of choice among different therapies. Without such choice, the price-sensitive buyer would have little room to negotiate lower prices or seek out lower cost alternatives. Me-too drugs, often derided as contributing little to health care, become valuable agents of choice in a market with price-sensitive buyers. The more close substitutes available in any therapeutic drug category, the higher is the potential for lower prices through price competition.

Fortunately for price-sensitive buyers, most of the new drugs entering the world market in recent years have been "me-too" drugs. A 1990 European study of the therapeutic value of NMEs first introduced in at least one of seven industrialized countries between 1975 and 1989 found that only 30 percent were classified by a group of experts as adding therapeutic value compared to compounds already on the market. The rest were essentially me-too drugs.⁵

Prices Differ Across Countries--Not only is the market for prescription drugs segmented among different classes of buyers in the United States, but it is also segmented internationally. Pharmaceutical companies charge different prices for the same drug in different countries.

Most other industrialized countries have universal health insurance that includes prescription drugs, so patients' demand for drugs is not very sensitive to the price charged. Nevertheless, the prices paid tend to be more strictly controlled by the third-party payers in these countries than in the United States. OTA studied the payment systems in five industrialized countries (Australia, Canada, France, Japan and the U.K.). All use some mechanism for controlling the price of patent-protected drugs. Four of the five countries do so directly by setting or monitoring prices for new drugs

3 Crawford, S.Y., "ASHP National Survey of Hospital-Based Pharmaceutical Services-1990," American Journal of Hospital Pharmacy 47:2655-2695, 1990.

4 Longman, R., "Alliances - The Way Forward," Scrip Magazine, December, 92/January 93, p 22.

5 Barral, P.E., "Fifteen Years of Pharmaceutical Research Results Throughout the World 1975-1989," (Antony, France: Foundation Rhone-Poulenc Sante, August 1990).

based on the cost of existing therapeutic alternatives. The pricing policies in these countries reward pioneer drugs with higher prices than me-too drugs, although the prices of pioneer drugs may still be low in comparison with those obtained in the United States.

These countries obtain lower prices for new drugs through pricing systems that do not rely on price competition to determine the demand for prescription drugs. They use price regulation or price control. National politics enters into some of these systems of price control. In some countries, for example, products either developed or manufactured in the home country are allowed higher prices than other products. In contrast, prices in the United States are determined in the market, but because of the structure of health insurance, a large part of the market gives inadequate consideration to price in making prescribing and purchasing decisions.

5. Generic Competition after Patent Expiration--Once a drug loses patent protection, it is vulnerable to competition from copies whose therapeutic equivalence is verified by the FDA. These "generic" competitors compete largely on the basis of price, since they can claim no quality advantage over the brand-name drug that they copy.

Price-sensitive buyers can make maximum use of generic drugs, whose prices are often much lower than the brand-name originator drug they copy. OTA looked at 35 drugs that came off patent between 1984 and 1987. The ratio of the average generic (non-originator) price to the originator's price declined quickly in the years following patent expiration as new competitors entered the market. Within five years after the expiration of the originator's patent, the average non-originator price was only one-fifth of the originator's price (Figure 3).

When patients and their prescribing physicians are not price sensitive, they will not always switch to generics despite their lower prices, unless they are given a financial incentive or penalty for staying with a high priced brand name drug. OTA found that as of 1990, despite the price differential between brand name and generic drugs, the brand name drug maintained about 40-50 percent of the market in physical units fully 5 years after patent expiration (table 4). The originator's dollar share was even higher, because the price of the brand name originator drugs increased in the face of competition from generics.

Implications for Cost Containment

Taken together, the 5 characteristics of the prescription drug market suggest both opportunities for and barriers to cost containment. In general, health insurers have done little to influence or control the prices or use of prescription drugs in the United States. But, in recent years, health insurers have turned their attention to their rapidly rising prescription drug costs, putting in place new cost-containment approaches. The main approaches used to contain prescription drug costs are described briefly below.

Incentives to Use Generic Drugs--Perhaps the easiest approach to containing prescription drug costs is for insurers to encourage or insist that prescriptions be filled with the lowest cost product available. The most common incentive in private health plans is a lower copayment when a generic drug is purchased instead of the brand name drug. In recent years insurers have increasingly turned to mail-order pharmacies as a way to increase the rate of generic substitution at the dispensing point. Mail-order companies locate their pharmacies in States whose laws are permissive toward generic substitution. Available data suggests that mail-order pharmacies do, indeed, fill a higher proportion of prescriptions with generics than do community-based pharmacies (Table 5).

Medicaid agencies have also tried to force a switch from brand name to generic drugs when generics are available. The Federal Government requires that across all drugs with generic competitors the State reimburse pharmacies no more than 150 percent of the published price for the least costly product. One big loophole in this regulation has been that any prescription on which the physician writes in his or her own hand that a specific brand is medically necessary is exempted from the reimbursement limits. Some States, for example, California, have been very successful in forcing generic substitution on virtually all drugs for which generic substitutes exist. On the other hand, a 1989 Florida study found almost 40 percent of prescriptions for such drugs were written with the physician's brand override and filled with the originator's brand. In 1990, Florida issued a rule mandating the use of available generics and essentially refusing to pay for brand-name drugs regardless of the physician override when generic equivalents exist.

Formularies--A formulary restricts the doctor's choice of drugs to those on a list (or to those not on a list of excluded drugs) when more than one therapeutically similar compound is available. Except for HMOs, formularies

do not exist in private health insurance plans. Recent surveys of HMOs indicate that between 28 and 55 percent of all plans have some type of formulary, but the nature of these restrictions has not been documented.⁶

Until 1991, State Medicaid agencies had the authority to establish formularies, and in 1990, about 22 states had restrictive formularies which limited reimbursable drugs to a defined list. Another 28 states had "open formularies" under which all drugs were reimbursable unless they were explicitly identified as ineligible. The effectiveness of these formularies in limiting Medicaid cost increases was never demonstrated. In any case, formularies were made illegal with the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), but now States may require doctors to get prior authorization for a drug if it has been approved by FDA for at least 6 months. Drug companies have argued that some States have used the prior authorization rule as a *de facto* formulary.

Drug Utilization Review (DUR)--DUR is the review of drugs prescribed or prescriptions filled to verify the drug's appropriateness, to identify potential interactions with other medications, or to identify alternative effective or cost-effective therapies for the patient.

DUR is a technology in its infancy. A recent GAO study described eight DUR programs, including some at retail chain pharmacies, one at a U.S. Department of Defense pharmacy, and one at a mail-order pharmacy. The emphasis of all of these programs was the improvement of patient outcomes (identification of adverse drug reactions or adverse interactions with other drugs), not to contain the costs of prescription drugs.

In OBRA 1990, Congress mandated the establishment of drug utilization review programs in State Medicaid programs by 1993. These programs are currently getting under way. The main focus of virtually all of these programs is on medication prescribing problems that put the patient's health at risk. DUR specialists believe that focusing on the quality of prescribing can reduce health care costs by reducing hospitalizations for inappropriate medications and other avoidable use of health care services, but these experts are quick to point out that there is at present almost no evidence that such results will occur.

Price Controls--OBRA-90 set in place for the first time a drug price control scheme that governs prices paid by Medicaid programs for patent-protected drugs as well as for those with generic competitors. The law required manufacturers who sell drugs to Medicaid patients to give States a rebate on their Medicaid purchases. One part of the rebate is required whenever the prices of a manufacturer's brand name drugs increase faster than general price inflation. The other part of the rebate is based on the difference between the Medicaid price and the lowest, or "best price" offered by the company to any buyer. If companies give large discounts to HMOs or hospitals, for example, they must also give them to Medicaid.

Ironically, the Medicaid "best price" rebate may have reduced HMOs' and hospitals' ability to negotiate discounts with manufacturers. Suggestive evidence is accumulating that manufacturers may have eliminated many such discounts when they found they would lose the amount of the discount on a large part of their total market. (Medicaid makes up 10 to 15 percent of the market for outpatient drugs.)

Until the end of 1993, the required rebate is calculated for each drug. Thus, the price of each drug sold to Medicaid patients must increase no faster than general inflation. However, new drug products (including new dosage strengths or dosage forms) may be introduced at any price. This pricing flexibility for new drug products encourages the development and marketing of new products, including relatively trivial changes in product formulations or packaging. What happens after 1993 is hazy--the law spells out a price system that indirectly controls the entry price of new drug products, but it also gives the Secretary of Health and Human Services the authority to change this part of the rebate formula.

Cost Containment Choices

In providing a drug benefit for Medicare beneficiaries, Congress will have to carefully consider the alternative approaches to containing drug costs. Without a strategy for cost control, universal coverage of the Medicare population for prescription drugs, when combined with strong patent protection on new drugs and physician ignorance and indifference to price, will create a tinderbox for price escalation. The history of private

6 Weiner, J.P., A. Lyles, D. Steinwachs, et al., "Impact of Managed Care on Prescription Drug Use, Health Affairs, 10(1):140-153, Spring 1991.

insurance and Medicaid in this country, and of drug insurance benefit plans in other industrialized countries, indicate that three general approaches to cost control are possible: 1) control drug prices; 2) regulate drug utilization; or 3) make the market for prescription drugs more price competitive. Selection from among these three approaches will ultimately determine not only the costs of a Medicare drug benefit but the level and patterns of innovation on new drugs in the future. The third alternative holds promise of sending the most appropriate signals to the developers of new drugs about what kinds of research will be most useful and therefore valued. But price competition is feasible only if doctors can be induced or required to become more price-sensitive in their prescribing habits. HMOs or other tightly managed health care plans which can establish and enforce formularies appear to be ideally suited not only to bring about this result but also to use their power to exact price concessions from manufacturers. It is probably unrealistic, however, to expect most Medicare beneficiaries to join HMOs in the foreseeable future.

Table 1
HMG-CoA Reductase Inhibitors Currently or Formerly Under Development

Compound	Sponsor	Approval Status
lovastatin	Merck	IND: April 1984. NDA: November 1986. Approval: August 1987.
pravastatin	Sankyo, Bristol-Myers Squibb	Launched in Canada, Europe, Japan, and Mexico. U.S. NDA: January 31, 1989. U.S. approval: November 31, 1991.
simvastatin	Merck	Launched in at least 17 countries worldwide, including most of Europe. U.S. NDA: November 1986. U.S. approval: December 1991.
colestolone	American Cyanamid	Entered U.S. clinical trials in 1987.
fluvastatin	Sandoz	U.S. NDA filed March 1992.
cerivastatin	Pan Medica	Phase II clinical trials.
dalvastatin	Rhone-Poulenc Rorer	Phase III clinical trials.
BAYW6228	Bayer	Phase II clinical trials.
HR780	Hoechst	Phase II clinical trials.
CI 981	Warner-Lambert	Phase I clinical trials.
BB-476	British Bio-technology	Series of compounds under development; preclinical.
BMV-22566	Bristol-Myers Squibb	Preclinical studies.
SQ-33600	Bristol-Myers Squibb	Preclinical studies, discontinued.
BMV-21950	Bristol-Myers Squibb	Phase I clinical trials.
GR-95030	Glaxo	Preclinical studies, discontinued.
SC-45355	Searle	Preclinical studies, discontinued.
L-659699	Merck	Preclinical studies.
L-669262	Merck	Preclinical studies.
CP-83101	Pfizer	Preclinical studies.

SOURCE: Office of Technology Assessment, 1993.

Table 2

Percent of U.S Population With Outpatient Prescription Drug Coverage, 1979 and 1987^a

	1979	1987
People under 65.....	71-73	73-77
People 65 and over.....	36	43-46
Total.....	67-69%	70-74%

^a A detailed memorandum describing OTA's methods in preparing this table is available upon request.

SOURCE: Office of Technology Assessment, 1993; based on sources listed in table 10-2.

Table 3

Limitations of Prescription Drug Benefits Among Nonelderly People With Private Health Insurance Covering Prescription Drugs

	1977 ^a	1989/1990 ^b
Full coverage	3%	3%
Separate limits (copayments) ^c	9	30
Overall limits (major medical) ^d	88	61
Other limits ^e		7

^a Results based on 1977 National Medical Care Expenditure Study Survey of employers and insurers of individuals under 65 years of age.

^b Results based on U.S. Bureau of Labor Statistics 1989 and 1990 surveys of employers.

^c "Separate limits" refers to restrictions applicable only to prescription drugs, such as a copayment for each prescription.

^d "Overall limits" refers to restrictions applicable to a broader set of medical services. For example, a major medical policy may carry a \$100 deductible and 20-percent coinsurance rate that applies to all covered services, not just prescription drugs.

^e Other limits include policies that combine fixed copayments with overall limits.

SOURCE: Office of Technology Assessment, 1993

Table 4

**Originator's Market Share for 35
Compounds Losing Patent Protection 1984-87**

Year^a	Dollar Sales	Unit Sales^b
-7	100%	100%
-6	99	100
-5	99	100
-4	99	100
-3	99	100
-2	99	100
-1	99	100
0	95	94
+1	86	73
+2	84	65
+3	84	57
+4	85	51
+5	83	44
+6	85	62

^a Year 0 is the year of patent expiration.

^b Unit sales are measured in defined daily dose.

SOURCE: Office of Technology Assessment, 1993, based on S.W. Schondelmeyer, "Economic Impact of Multiple Source Competition on Originator Products," contract paper prepared for Office of Technology Assessment, U.S. Congress, December 1991.

Table 5--Percent of Prescriptions for Multi-source Maintenance Drugs^a
 Dispensed with Brand-name and Generic Products,
 January-September 1992

Market sector and drug type	Rx volume	Rx dollar value ^b
Mail order		
Brand-name	27.6 %	53.6 %
Generic	72.4	46.4
Retail ^c		
Brand-name	44.1	67.6
Generic	55.9	32.4

^a Maintenance drugs are generally used for long-term therapy.

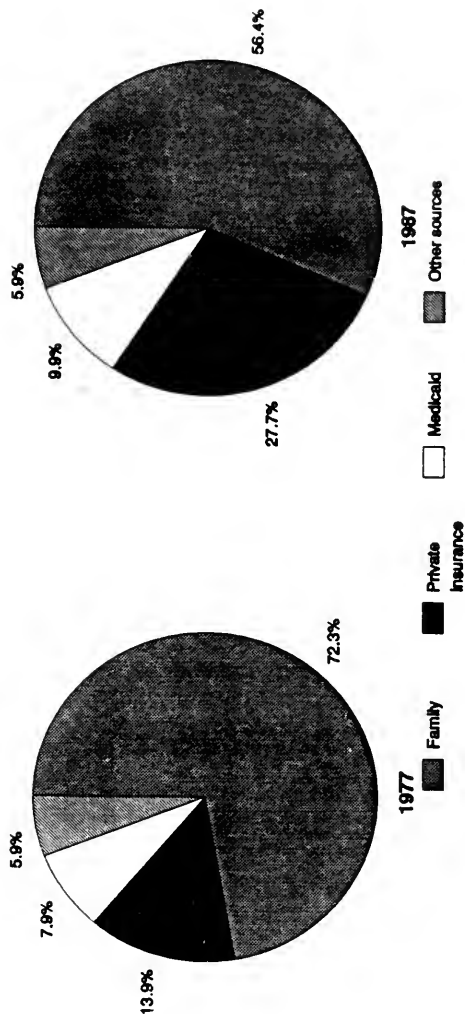
^b Dollar value is derived from the average wholesale price.

^c Prescriptions ordered through Medco's retail prescription programs. Some of these programs actively promote incentives to encourage dispensing of generic products.

KEY: Rx - prescription drug

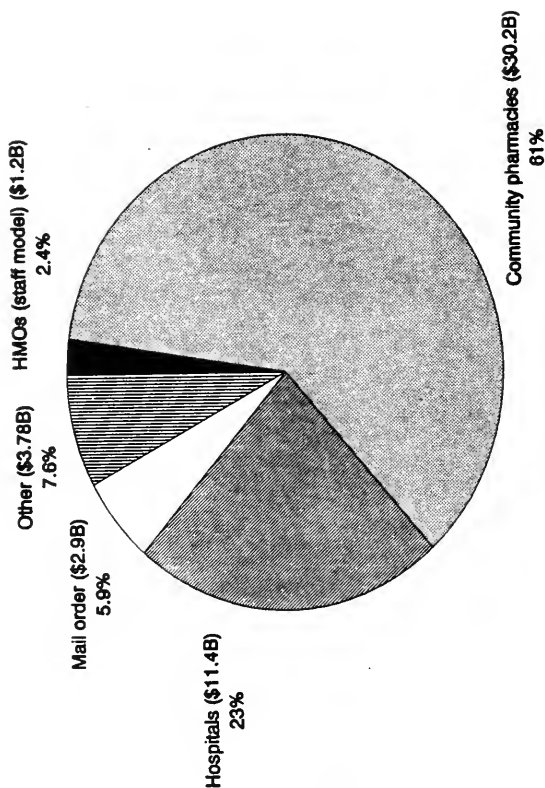
SOURCE: Medco Containment Services, Inc., 1993.

Figure 1--Sources of Payment for Prescribed Medicines in the United States



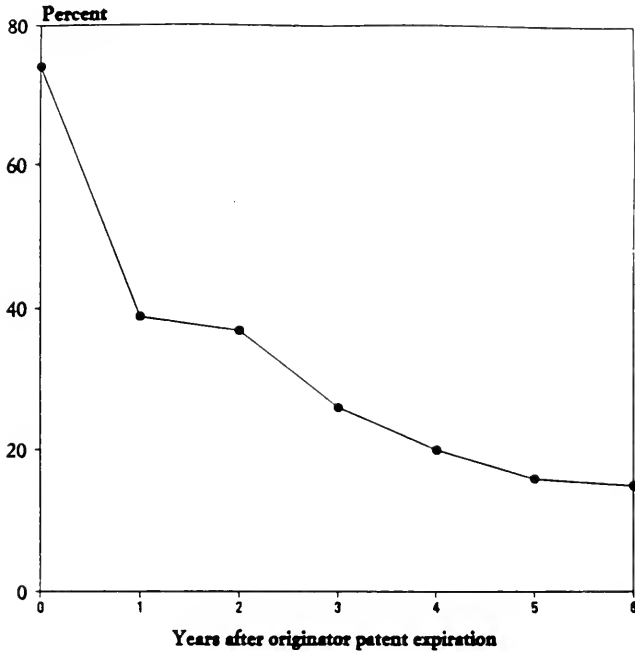
Source: Data from J.F. Moeller, Senior Project Director, U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Rockville, MD, personal communication, Mar. 12, 1991; J.A. Kasper, Prescribed Medicines: Use, Expenditures and Sources of Payment, Data Preview (Washington, DC: U.S. Department of Health and Human Services, National Center for Health Services Research, April 1982).

Figure 2--Pharmaceutical Sales in the United States by Trade Channel, 1991



Source: IMS America, Inc. as cited in F-D-C-Reports: *Prescription and OTC Pharmaceuticals*, "Mail Order Grew 37% to \$2.9 Bil. in 1991 IMS Survey; Growth May Slow Soon," p. 11, Mar. 16, 1992.

Figure 3—Non-Originator Price as a Percent of Originator Price* (\$ 1990)



* Average revenue ($\text{\$Sales/DDD}$), of non-originator drugs divided by average revenue of originator drugs.

Source: Office of Technology Assessment, 1993, based on S.W. Schodelmeyer, "Economic Impact of Multiple Source Competition on Originator Products," contract paper prepared for Office of Technology Assessment, December 1991.

Mr. CARDIN. The market conditions that you refer to with regard to pharmaceuticals, the four points that you mention, it seems to me that three of the four are similar to conditions that exist for other medical services and insurance coverage. There is wide coverage for physician care or for hospital care.

Physician ignorance is not only true as far as the cost of prescription drugs, but I would assume it is true as far as tests that physicians order in many cases. The submarkets, we have price discrimination or price shifting in many medical services today where physicians can charge different prices for different markets. But the patent law is truly unique to the pharmaceutical industry.

Is that the primary matter that needs to be looked at in dealing with controlling the pharmaceutical industry? You mentioned it first. Was that by design?

Ms. WAGNER. I think that the existence of patents and strong patents for this class of goods—other medical technologies are subject to patent as well, but the patents are usually not as strong as they are for chemicals and drugs. I think that binds together the other three and makes it particularly difficult to establish the kind of pricing controls that we have seen with physician services, with laboratory procedures, and with hospital services.

In this country patent protection gives the producer the right to charge what the producer wishes to—chooses to charge. We have patent protection in other areas, other sectors of the economy, of course, but in those other sectors, there is price sensitivity in the market and so for example when we have a Tagamet and Zantac, two patented drugs which are therapeutically similar, and there are more—I should probably know the names of all of them for equal time—the H-2 antagonist market has 5 or 6 drugs in the category.

In other markets, there would be price-sensitive buyers and they would be driving the prices down even of those patented drugs.

Mr. CARDIN. The problem is complicated because of the other market conditions of the patents?

Ms. WAGNER. It all hangs together.

Mr. CARDIN. The patent protection is looked upon as the major incentive for pharmaceutical manufacturers to take the risk to develop new products that are obviously enjoyed and needed by the American consumer.

Is there a need to look at a change in the patent law from the way that you have reviewed the situation?

Ms. WAGNER. I am not an expert on the patent law. The patent law is essentially grounded in the Constitution of the United States, and I am not a lawyer, so it is difficult for me to say much about the extent to which we could do something different with pharmaceuticals that we might not want to do in general.

I do want to stress the fact that once patent protection is over, then this market has the potential to work very, very well, very effectively and very price competitively. So the real issue is whether or not we can afford a system that is price insensitive for the length of time that patents exist.

Mr. CARDIN. Of course, if the patents are needed in order for the products to be discovered, following your analysis, we have to work

on the other market conditions perhaps to mitigate some of the adverse impact of the patent protection.

Ms. WAGNER. Yes. I think if you look at specific, very big therapeutic categories of drugs, you see a lot of entrants into the field. Ace inhibitors, a big cardiovascular area of drugs, very important for the elderly, have at least six and possibly eight different agents on the market today. The question is how to make prescribers sensitive to those prices.

Mr. CARDIN. In order to get the generic drugs, we have to get to the prime drug originally.

Ms. WAGNER. Yes, but even within the patented drugs, there is a lot of therapeutic choice.

Mr. CARDIN. Mr. Thomas.

Mr. THOMAS. In your study, was there any indication that the rest of the world is basically living off of the strong patent structure in the United States for development of new drugs?

Ms. WAGNER. What you are asking I think is whether or not the low prices that exist in other countries are in a way subsidized—

Mr. THOMAS. Are there new drugs that are coming on the market that are developed in other countries? If they have patent processes how do they compare with the United States? Where does the United States stand in terms of creating new and unique drugs versus other countries? It seems to me if we discuss a strong patent law you can't discuss it without a comparison in terms of what the rest of the world is doing in producing new and unique drugs.

Ms. WAGNER. The United States is a leader in the development of new chemical entities.

Mr. THOMAS. Do you think there is a relationship between that and a strong patent?

Ms. WAGNER. We didn't study the competitiveness aspects. I will say I think it is a complicated issue. The origin of the strength for the American pharmaceutical industry may stem as much from the research infrastructure that the United States offers through its tremendous investment and subsidization of research, academic research, and the natural advantage that American companies have had in accessing that research infrastructure as it does from other kinds of public policies.

Mr. THOMAS. Most of that research infrastructure is made public and other scientific entities, universities, private researchers, companies around the world utilize that information as well. Do they wind up creating new and unique drugs at the rate the United States does?

Ms. WAGNER. Other industrial countries do have active pharmaceutical research industries. The United Kingdom is very strong—

Mr. THOMAS. How many drugs have they patented over the last 10 years?

Ms. WAGNER. I don't know exactly, but I have the data in my office and will get it for you.

[The information follows:]

CLASSIFICATION OF COUNTRIES DISCOVERING GLOBALIZED PRODUCTS IN THE
PERIOD 1975-89¹

		Products	Percent
1	USA	47	48.4
2	Great Britain	14	14.4
3	FRG	9	9.3
4	Japan	5	5.1
4	Switzerland	5	5.1
4	Belgium	5	5.1
7	Sweden	4	4.1
8	France	3	3.1
9	Italy	2	2.1
9	The Netherlands	2	2.1
10	Other countries	1	1.0
		97	100.0

¹ Globalized products are defined as products marketed in all of seven industrialized countries.

Source: P. Barral, *Fifteen Years of Pharmaceutical Research Results Throughout the World (1975-1989)*, Foundation Poulenc-Sante, 1991.

Mr. THOMAS. My concern is you start your paper with the patent question and I assume there is a rationale for that in terms of leading through the discussion of costs. It seems to me that one of the primary problems is the fact that nobody cares what they cost because of the insurance structure and the people who prescribe the drugs don't know how much they cost because they are not players in the outcome of what it costs, and that to a very great extent those are areas that we can work on.

Do you believe that the costs, especially of the new and unique drugs, are basically ripoffs in terms of the American society?

Ms. WAGNER. I don't think that we have the information to answer that question.

Mr. THOMAS. Do you have any data on the cost to bring a new drug to market?

Ms. WAGNER. We actually spent probably too much of our lives, Dr. Gluck and I, in looking at that question.

Mr. THOMAS. Is it a lot?

Ms. WAGNER. It is a great deal. It is even more than what the industry claimed it was when we began the study.

Mr. THOMAS. Are drug manufacturers government entities or private sector structures?

Ms. WAGNER. That is an easy question to answer. Of course they are private.

Mr. THOMAS. If they don't make a profit, can they continue to expend these enormous amounts that even you and Dr. Gluck believe was greater than they thought it was in developing them?

Ms. WAGNER. In order for pharmaceuticals—they are businesses—to make a return on their investment. The investors in pharmaceutical R&D, to put each dollar down, must be able to expect that that money will give a return that is sufficient to justify the risk of that investment.

Given that, the real question is, what signals is this market giving to that industry about what it will pay for, how much it will pay for and what kind of R&D it will pay for. There is a real question about the signals from the market and whether those signals which say pump R&D into duplicative products, me-too products, is the most socially desirable set of signals.

The real issue is whether the market is sending appropriate signals, not whether the industry is responding appropriately.

Mr. THOMAS. My concern is not so much about the me-too. We could spend time talking about that. Copying is easy and if there is a profit to be made in copying versus original work, people will copy. My concern is in the work that the pharmaceutical companies have done in new and unique areas which take enormous amounts of research and development and the only yardstick that I know of that provides some assurance to people who are willing to invest in this risky field is the fact that you do have a patent law and if you do succeed in coming up with a new compound, you do have a period in which you can recoup the costs.

My concern is not this long time in which people can charge whatever they want to charge, but the fact that government is eating up such a significant portion of that guaranteed time in the approval process that they go through. Do you have any indication that there has been a significant change over the years, relative to the complete patent time on a new product in terms of the time it takes government to OK it?

When does the clock start on a patent and how much time is consumed by government before the pharmaceutical company has a chance to go out and to make money on this new product?

Ms. WAGNER. In recent years, the length of effective patent life has improved since the passage of the Drug Price Competition Act. It has gone up somewhat. In addition, there have been new laws that have essentially granted market exclusivities for follow-on products and for orphan products which are very useful to the biotechnology industry in particular, but also to other drugs.

There has overall been an improvement of what we call the effective patent life in recent years.

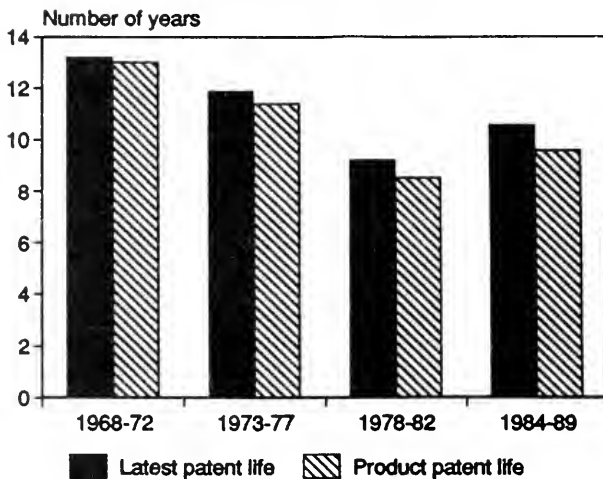
Mr. THOMAS. Significant improvement or just an improvement?

Ms. WAGNER. Significant is a matter of judgment. It is in our report and I would be happy to send it to you. It is on the order of a year to 2 years extra patent life since the 1984 Act.

The real question that you are asking is how do we give the appropriate signals for returns on important new therapies and at the same time not send signals to do wasteful R&D. That is a difficult public policy issue.

[The information follows:]

**-Effective Patent Life for
Drugs Approved, 1968-89**



SOURCES: Office of Technology Assessment, 1993. Based on U.S. Congress, House of Representatives, Committee on Energy and Commerce, unpublished data, 1993; U.S. Department of Health and Human Services, Food and Drug Administration, unpublished data, 1991; U.S. Department of Commerce, Patent and Trademark Office, unpublished data, 1991.

Mr. THOMAS. My second problem is, and it is the same in almost any kind of a research and development, that you have to pay for a lot of dead-end work on your few winners. I am very much concerned if the government begins to try to determine what is appropriately charged for one particular product on R&D only for that product versus an understanding that if it is a big winner, you ought to be able to get big profits to be able to do other areas of work. My biggest concern is that if we compare what is going on in other countries with the United States in terms of unique products, I am concerned about focusing on changes in patents or control of patents, and the ability of pharmaceutical firms getting a return on investment.

I much prefer starting at the bottom of the line with the question of insurance, and an understanding by the consumer of the cost, dealing with those who copy and that the very last thing we do is deal with the protections provided to those people who are willing to risk their own money to develop new and unique products that clearly have been beneficial.

Thank you very much.

Mr. CARDIN [presiding]. Mr. Stark will inquire.

Chairman STARK. Thank you, Mr. Chairman.

Dr. Wagner, let me just followup on your study. You looked at R&D costs and returns and you found the drug manufacturers made, in your words, excess profits above the expected and necessary return.

Do you want to comment on how much excess profit, how you determined what is excess?

Ms. WAGNER. Getting to the returns on R&D was no simple task. I want to emphasize how difficult it is to get information on, for example, sales revenues here and worldwide, which is very important in measuring returns. It is available. The industry has access to it and it is actually for sale, but it was not for sale to OTA at a price that would not help put OTA out of business fast.

So access to data to measure the profitability of the industry is very difficult. We used what data we could find to look at a sample of drugs that were introduced in the early 1980s. We found that for each new drug, the net excess after tax return—and when we say excess, we mean above and beyond the requirements to repay the investment at a reasonable cost of capital for its risk, that excess return—

Chairman STARK. What kind of an internal rate of return for instance?

Ms. WAGNER. We used—actually on R&D, we used a varying rate of return between 10 and 14 percent, 14 percent for early rate R&D. That is a real rate of return.

On the revenue side, we used a 9.8 percent rate of return. That was based on academic studies that we had commissioned. At any rate, we found that for each drug measured in 1990 dollars, it returned \$36 million excess profits on average. Some were very profitable; others were not profitable.

On average, they returned \$36 million excess per drug. In addition, we also used company financial data and measured the profitability companywide from 1976 through 1987, a 12-year period. This was commissioned from an academic study, and that group found that the excess profits of the pharmaceutical industry compared to two matched control groups of companies were on the order of 2 to 3 percentage points a year. This 2 to 3 percentage points difference a year over that period could not be explained by differences in risk between the pharmaceutical industry and the control groups.

So we concluded that, in the period we looked at that, these are not as high excess returns as is often publicized. They are much lower than for example the Fortune 500 rates of return that compare the pharmaceutical industry with other industries. That is because R&D is an intangible investment that doesn't show up in industry accounting books as an investment.

But one thing I should emphasize is that returns are very volatile and what these returns seemed to do is to send a signal to the industry that it should invest and invest and invest in R&D, and it did that throughout the 1980s.

Chairman STARK. Let me interject an anecdote, but maybe you could check me on this. I would love to find out how far off we were in our calculations. We looked at Amgen for the IPA stuff and they weren't willing to give us a lot of information, but through their SEC reports you could take their aggregate expenditures. That is pretty hard to hide; every nickel they spent from the day they started the company.

We said "All right. We will spot you that, give you all your money back, including the dry holes, and see how you price IPA;

give you all your money back and give you a 30 percent internal rate of return over the entire time that the company has been in business and project that out and give you the CPI on top of that," and they thought the price was too low. They thought they should get more than that.

Does that sound like a pretty generous return?

Ms. WAGNER. This is a complicated problem and I am not going to answer a simple yes. For every Amgen, there are four or five biotechnology companies that go under because the investor is diversifying across all those companies. Whether or not the price for Amgen is fair is something that I don't know about.

Chairman STARK. It sounded like a very generous—

Ms. WAGNER. They certainly were a good investment.

Chairman STARK. So, I have to do that for all the companies that have yet to produce a product and add that to the Amgen cost in a sense to get a return to an investor who would buy a package of these things.

Mr. GLUCK. Also the ones that didn't make it as well.

Chairman STARK. So you have to take some bigger universe of companies like a venture fund would do rather than just take the one company.

Ms. WAGNER. Yes.

Chairman STARK. The venture funds don't do bad as a practical matter.

One other question, if I may. The testimony that we will hear later by the pharmaceutical manufacturers strongly supports managed care and managed competition as a cost containment strategy. But in your testimony you suggest that with the exception of staff model HMOs, managed care plans such as IPOs and PPOs really haven't been very successful in controlling drug costs.

In your view, why are the IPOs and other plans unsuccessful and what does that say about the chance for things like managed competition or managed care to be the sole source of controlling our costs?

Ms. WAGNER. I think the key to effective—to making an organization effective and being able to affect physician prescribing behavior and negotiate drug price rebates is the ability to create and enforce a formulary in which the organization can decide that among those six Ace Inhibitors, it will buy and require its member physicians to prescribe only Ace Inhibitor No. 1, and if the prescribing physician wants to do 2 through 6, some special exception process will be necessary.

That kind of tight control, formulary control, is the key. Staff model and group model HMOs are ideally suited to set up those kinds of formulary structures. IPAs and other kinds of managed care, PPOs, there is nothing to say that they couldn't do that, but they haven't done it certainly to the extent and it is probably much more difficult when you are dealing with a wide array of member physicians who are—who have a few of your patients but many of their own patients to try to control their prescribing practices.

So I think it is not that it is not feasible. It would probably be more costly and more difficult to implement; but it simply is not there to the extent that you would assume when you hear how

much managed care there is. Managed care doesn't mean very closely controlled pharmaceutical—

Chairman STARK. How would managed competition enter into this? If you had between IPOs or managed care plans, would there be any real reason for them—

Ms. WAGNER. If the vast majority of the market were in very price-sensitive organizations, managed care organizations, which could affect—gave real incentives to their physicians to prescribe, then one would assume that these P&T committees, the formulary committees would be making decisions that would say, "Here is Ace Inhibitor No. 1. It is 30 percent less in price. We are going to go with it. There is not sufficient evidence that it is substantially better. We are going to go with this." If these decisions were made over and over again across the large number of organizations it would certainly have an impact on the transaction prices in the market.

Chairman STARK. Your study would show that you would have to structure that, that won't just happen?

Ms. WAGNER. I am not an expert—I do know that something like 3 percent of the Medicare beneficiaries today I believe are in risk-based, managed care contracts, so it is not a high proportion of the Medicare population.

Chairman STARK. Thank you.

Mr. CARDIN [presiding]. Mr. Levin.

Mr. Brewster.

Mr. BREWSTER. Thanks for the opportunity to visit with you today.

I agree with Mr. Thomas that the strong drug patent laws that we have are one of the main reasons for the success of the industry. I think that without that, you would see many companies unable to spend the time on research that they do today.

Isn't it true that you may have a company, if they are looking for an H-2 antagonist, start with several hundred chemicals to come out with maybe one that can be patented. So there are many dry holes in what companies do in trying to be players in the market place today; is that correct?

Ms. WAGNER. Yes.

Mr. BREWSTER. Isn't it also true that under a patent process, that at the time you have to do your patents by the time you clear FDA, you may have only 7 or 8 years to try and recoup the money you spent on dry holes as well as make money for your investors?

Ms. WAGNER. The latest data we have available for the drugs introduced 1984 to 1989, the average is closer to 10 years, not including some of the follow-on market exclusivities. The other thing we found was that affective patent life increases in relation to the importance of the drug.

We found tentative evidence that companies essentially manage their patents more carefully on important drugs, on the big winners, the big money drugs, so that in fact the more important the drug is in terms of sales the longer the patent life.

Mr. BREWSTER. As you would expect a manufacturer to try to do. When you say an average of 10 years, there are probably some on the market with 6 or 8 years. You have some above, some below. So you have some pharmaceutical companies spending tremendous

amounts of money on products that they have a very short time to recover the cost.

You mentioned therapeutic substitution. Say an H-2 antagonist, if we had an opportunity to go with therapeutic substitution in a formulary system and required the least expensive, would that save a considerable amount of money?

Ms. WAGNER. Unfortunately I don't have actual transaction price data on the H-2 antagonists. In fact, we don't have good transaction price data on almost any drug. That is a major problem I think for governments right now. We don't know enough about what is happening.

You can't look at today's prices, for example in the community pharmacy market, and say what will be the savings if everybody were in a HMO, because the actual transactions prices in HMOs might be very different. You would get pricing changes.

I think that the savings would be great if we were able to set in place a system where the buyers became price-sensitive through this formulary process because that would put into force the kinds of price reactions, price reductions that you see in other dynamic R&D intensive, competitive areas such as computers.

Mr. BREWSTER. Would it not also be true though that one patient might not react well to Zantac and might react well to carafate. If you go strict therapeutic substitution, you could have an instance where a patient might not have access to a particular medication that could be extremely important to their recovery.

Ms. WAGNER. That is referred to as something that the pharmacist can do.

Mr. BREWSTER. In most States, pharmacists cannot therapeutically substitute.

Ms. WAGNER. Here we are talking about a decision made by a hospital or HMO P&T committee in which essentially the rule is the first line of prescribing is drug X and if there is an adverse drug reaction or some other reason to suggest another drug, then there is some exception process.

Mr. BREWSTER. If it is medically necessary to use something else?

Ms. WAGNER. Yes. That is why formularies at the local level are so effective, local being at the institution or the provider level, and formularies at the State or Federal level become much more difficult to administer because it is difficult to get the flexibility in there at the State or Federal level.

Mr. BREWSTER. You mentioned managed competition. I have feelings that the main savings that have occurred through some HMOs have been on the purchasing side and that while others in the same business may purchase at even larger quantities, they don't have the opportunity for the savings that some of the managed competition people do.

How in the world if everybody goes into a managed care environment will there be any cost shifting for those providers to be able to stay in business that are offering the low prices now? Currently the only way it works is if you sell to me at a very low price, and you raise the price to someone else.

Ms. WAGNER. Yes.

Mr. BREWSTER. If everybody goes into this environment, where is the savings?

Ms. WAGNER. It is not necessarily true that they are raising the price to everybody else—

Mr. BREWSTER. One medication I know of sold to some of the mail order companies for 8 cents a tablet; AWP to the retail pharmacist at 44 cents a tablet. Can you tell me they can make a profit and sell to everybody at 8 cents a tablet? If not, there is obvious cost shifting.

Ms. WAGNER. I don't know the answer to that specific question, but I will say that what was found with the Medicaid rebate is an example of the fact that prices would equalize under a system in which everybody was price-sensitive; you might find no discounting and the actual price go down.

Mr. BREWSTER. That is my point.

Without a mechanism of cost shifting somewhere else, the bottom price comes up as well and there is no saving.

Ms. WAGNER. It is a question of where the bottom price ends up. If there is a lot of therapeutic choice in a category, as there is in many categories today, it would seem to me that the competition would lower prices overall, but I am conjecturing here and I shouldn't.

Mr. BREWSTER. Thank you.

Mr. CARDIN. Let me thank you both for being here. That will conclude your testimony.

We now call the next two as a panel: Tess Canja, member, board of directors of the American Association of Retired Persons; and Martha McSteen, from the National Committee to Preserve Social Security and Medicare.

STATEMENT OF TESS CANJA, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION RETIRED PERSONS

Ms. CANJA. Thank you, Mr. Chairman and members of the subcommittee. I am Tess Canja and I am a member of the board of directors of AARP. We appreciate the opportunity to testify today.

AARP is a strong advocate of comprehensive health care reform and we firmly believe that access to prescription drugs must be part of a reformed system. Two years ago when we testified on this issue, we focused on how high prices, heavy utilization and the absence of affordable insurance coverage for prescription drugs had significantly reduced access to needed drug therapies for many older Americans, and that situation has not improved.

Today, however, with some confidence that a prescription drug benefit for all Americans will be included in the administration's health care reform proposal, I will focus on six basic principles of how we believe such a benefit should be structured.

The first is guaranteed access to needed drug therapies. AARP is extremely concerned about the affordability of prescription drugs particularly for older Americans.

A recent survey sponsored by AARP showed that older Americans use significantly more prescription drugs than other age groups to maintain their health. Prescription drug insurance coverage, however, declines rapidly as age increases as you can see on the chart. Only 40 percent of older persons have 40 percent coverage as compared to 75 percent for younger groups. And, out-of-

pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

My 86-year-old mother is a case in point. She has two conditions common to persons of her age, Parkinson's disease and heart disease, and she is spending one-third of her Social Security on prescription medications. She can't afford to spend one-third of Social Security on prescription drugs, but without the drug, she would be vulnerable to much costlier hospital or nursing home care.

Second, AARP strongly believes that effective cost containment must be part of any prescription drug benefit or the benefit may quickly become unaffordable to both taxpayers and beneficiaries. As you will recall, this was clearly the case during the development of the Medicare Catastrophic Coverage Act. Due to lack of effective cost control, the projected cost of the catastrophic drug benefit and the resulting premiums to be paid by beneficiaries skyrocketed even before the bill made its way through the conference committee.

Because of this, AARP is concerned about the voluntary price restraints proposal currently advocated by the pharmaceutical industry. We view this method of cost containment as an entirely inadequate method of constraining drug prices. Indeed several pharmaceutical companies that are currently operating under such voluntary restraints have already gamed the system to their advantage and to the detriment of cash-paying consumers.

AARP believes there are more effective ways to contain drug prices, including the Prescription Drug Prices Review Board Act of 1993 that you, Mr. Stark, recently introduced. Your bill offers a sensible way to begin curbing the uninhibited growth in prescription drug prices, but there are other methods that also merit consideration, including direct price controls, requiring manufacturers to sign fair pricing agreements as a condition of doing business with any Federal Government program and establishing formularies and requiring manufacturers to compete based on price and quality.

We are all familiar with the argument made by the industry and their high-priced, full-page ads that every dollar you seek in cost containment will come directly out of research and development of important breakthrough medications.

Mr. Chairman, this is a clear case of false and misleading advertising. Much more goes into the price of a drug than legitimate research and development. If you take a look at the other chart, you can see that only 16 percent of the manufacturer's price of a drug goes toward research and development compared to the 23 percent that goes toward marketing and advertising and the 13 percent that is profit.

AARP believes the industry could bring its profits down to a more reasonable level and cut back on excessive promotional activities without harming legitimate research and development endeavors.

Third, we are concerned about how the new drug benefit will be financed. To the extent that the benefit for older Americans is financed through an increase in the Medicare part B premium, we believe the premium should cover approximately 25 percent of program costs as is the case with current part B financing. The re-

mainder of the financing should come from a source or sources that are stable, broad based and reasonably progressive.

Fourth, AARP strongly believes that the structure of the prescription drug benefit for those age 65 and older should be parallel to the structure of the benefit for those under age 65. Specifically, coinsurance and deductibles should not differ based on age and financing should be equitable across all generations.

Fifth, in order to ensure that individuals of all ages have access to needed medications health care reform must include special protections for those with low incomes; and six, to reduce the incidence of adverse drug reactions, mismedication, overmedication and inappropriate prescribing practices, the benefit should include an effective Drug Utilization Review program that focuses on prevention, education, enforcement and high standards.

Thank you for giving AARP the opportunity to testify today. We look forward to working with you.

Chairman STARK [presiding]. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF TESS CANJA AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning Mr. Chairman and members of the subcommittee. I am Tess Canja, a member of the Board of Directors of the American Association of Retired Persons (AARP). AARP appreciates the opportunity to testify today on how a prescription drug benefit should be structured under health care reform. AARP is a strong advocate of comprehensive health care reform, and we firmly believe that access to prescription drugs must be part of a reformed system.

When we testified on this issue before this subcommittee two years ago, we emphasized the growing need for a Medicare prescription drug benefit. Our testimony then focused on how the combined effects of high prices, heavy utilization, and the absence of affordable insurance coverage for prescription drugs have significantly reduced access to needed drug therapies for many older Americans. This situation has not improved and, as a result, older Americans remain vulnerable to avoidable health problems and more likely to receive unnecessary and more expensive medical care.

Today we are more confident that a prescription drug benefit for all Americans will be included as an integral part of the Administration's health care reform proposal. Our testimony will focus on some basic principles of how we believe such a benefit should be structured. Specifically, AARP strongly believes that a prescription drug benefit must:

- o guarantee access to needed drug therapies;
- o contain costs effectively;
- o rely on stable, broad-based, and equitable financing;
- o provide for a parallel benefit structure across all ages;
- o protect low-income beneficiaries from exorbitant costs; and
- o encourage appropriate prescribing, monitoring, and use of medications.

Guaranteed Access

AARP is committed to expanding access to quality, affordable health care. In this regard, we have developed a health care reform proposal called "Health Care America" which guarantees access to health and long-term care services for all Americans and includes coverage for prescription drugs. We view our proposal as both a vision statement for the Association and a standard for evaluating other reform proposals.

In regard to prescription drugs, we are extremely concerned about the lack of access, particularly among older Americans. A recent national survey sponsored by AARP showed that:

- o older Americans use significantly more prescription drugs than other age groups to maintain their health;
- o prescription drug insurance coverage declines rapidly as age increases (see Chart I); and
- o out-of-pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

As a result, many older Americans cannot afford high prescription drug prices and are too frequently denied access to essential,

often life-saving, medications -- compromising their health status and making them more likely to receive unnecessary and more expensive acute care. About 10 percent of those surveyed said they have had to cut back on necessary items, such as food and heating fuel, to afford their medications.

The incorporation of a prescription drug benefit in health care reform will ensure access to important, often life-sustaining, drug therapies to all Americans, especially those who are most vulnerable to losing access today. As you know, the Association has been a long-standing advocate for Medicare prescription drug coverage, and we look forward to continuing to work with you and your colleagues on developing a fair and equitable program that meets the needs of all Americans through health care reform.

Effective Cost Containment

AARP strongly believes that effective cost containment must be part of any prescription drug benefit. If effective cost containment is not included, the benefit may quickly become unaffordable to both taxpayers and beneficiaries. As you will recall, this was clearly the case during the development of the Medicare Catastrophic Coverage Act (MCCA). Due to the lack of effective cost containment, the projected cost of the MCCA drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through the conference committee.

In this regard, AARP is concerned about the "voluntary" price restraint proposals currently advocated by the pharmaceutical industry. We view this method of cost containment as an entirely inadequate method of constraining drug prices. Indeed, several pharmaceutical companies that are currently operating under such "voluntary" restraints have already gamed the system to their advantage and to the detriment of cash-paying consumers.

For example, a recent report by the Senate Special Committee on Aging revealed that, of the eight major pharmaceutical companies that made voluntary pledges to restrain their price increases in 1992 to the change in the Consumer Price Index (CPI), none met their goal in the outpatient sector -- which is primarily made up of cash-paying consumers. Indeed, the increase in outpatient prices for some of these companies was three to four times greater than the change in the CPI.

Many of these companies, however, have argued that they met their pledge by using a "weighted average" calculation of price increases, which includes the substantial discounts they give to the inpatient sector -- namely hospitals, health maintenance organizations, and other large buyers. While this may be technically true, it is clear that voluntary price restraints may have little if any impact on outpatient prices. More importantly, such actions call into question the seriousness which should be accorded the claims of a "new day" in pharmaceutical company attitudes toward drug prices. Clearly, voluntary price restraints by pharmaceutical companies that do not have an effect on the outpatient market will do little to improve access for Americans purchasing prescription drugs on an outpatient basis, particularly those paying cash.

In addition, voluntary price restraints do not address the "launch price" of new prescription drugs. AARP believes that the price of these new medications must also be restrained at justified levels to adequately contain costs. The stronger the cost containment, the more the Administration and Congress will be able to ensure access to needed drug therapies and restrain health care costs.

AARP believes there are more effective ways to contain drug prices, including the "Prescription Drug Prices Review Board Act of 1993" (HR 916), as introduced by Chairman Stark. This legislation offers a sensible way to begin curbing the uninhibited growth in prescription drug prices by creating a Prescription Drug Prices Review Board with the authority to link the availability of federal tax benefits and the length of patent terms to reasonable pricing practices by drug manufacturers.

Other potentially effective methods to restrain drug prices merit consideration. These include: 1) direct price controls; 2) requiring manufacturers to sign fair pricing agreements as a condition of doing business with any federal government program; and 3) establishing formularies and requiring manufacturers to compete based on price and quality. While AARP has not as yet established a position on any of these cost containment alternatives, we believe that voluntary price restraints are entirely inadequate.

The industry argues that every dollar sought by policymakers to contain drug prices will come directly out of research and development of important breakthrough medications. AARP believes that this is simply false. Much more than legitimate research and development activities go into the manufacturers' price of a drug; therefore, a drug manufacturer has many choices as to where they can be more efficient and cut costs. In fact, according to a recent study by the Senate Special Committee on Aging, only 16 percent of the manufacturers' price of a drug goes toward research and development compared to the 36 percent that goes toward profits, marketing, and advertising (see Chart II).

AARP believes the industry could bring its profits down to a more reasonable level and cut back on excessive promotional activities without harming legitimate research and development endeavors. We agree with David Kessler, the Commissioner of the Food and Drug Administration, when he recently stated, "If you cut industry promotion in half, you won't lose anything, I can assure you."

Stable, Broad-Based, and Equitable Financing

AARP is also concerned about how the new drug benefit will be financed. To the extent that the benefit for older Americans is financed through an increase in the Medicare Part B premium, we believe the premium should cover approximately 25 percent of program costs, as is the case with current Part B financing. The remainder of the financing should come from a source or sources that are stable, broad-based, and reasonably progressive.

Excise taxes have also been suggested as a means of paying for health care reform, including a prescription drug benefit. AARP believes that excise taxes can play a role in financing health care reform, but we recognize that such taxes are not a stable source of revenue. To the degree that excise taxes discourage consumption, which is often their broader social purpose, they will generate less revenue. A more stable source of financing must also be part of the revenue base so that the benefits will not be jeopardized in the future.

Parallel Benefit Structure for Medicare and Non-Medicare Beneficiaries

AARP strongly believes that the structure of the prescription drug benefit for those age 65 and older should be parallel to the structure of the benefit for those under age 65, specifically:

- o coinsurance and deductibles should not differ based on the age of the beneficiary;

- o financing should be spread equitably across all generations.

With regard to deductibles, in 1990 approximately 81 percent of Medicare Part B enrollees met their \$100 deductible and received benefits from the program. Given the link between physician visits and prescription drug use, a deductible for prescription drugs that allows 80 percent of beneficiaries to get coverage should be considered. Also, the Association believes that the drug benefit should provide protection against prescription drug costs that is comparable to that for physician services by requiring a coinsurance of no more than 20 percent.

We believe that a parallel structure in the prescription drug benefit between Medicare and non-Medicare beneficiaries will ultimately be very important in generating support among older Americans.

Low-Income Protections

In order to ensure that individuals of all ages have access to necessary medications, health care reform must include special protections for those with low incomes. For example, the prescription drug benefit should expand the current Qualified Medicare Beneficiary (QMB) program to cover Medicare's premiums, coinsurance, and deductibles for low-income Medicare beneficiaries. Specifically, beneficiaries with incomes below 150 percent of the poverty level should have their premiums and cost-sharing (i.e., deductibles and coinsurance) paid for through the Medicaid program or other source. A parallel structure should also be established for those under age 65 under health care reform.

Appropriate Prescribing, Monitoring, and Use

To reduce the incidence of adverse drug reactions, mismedication, overmedication, and inappropriate prescribing practices, the prescription drug benefit should include an effective drug utilization review (DUR) program that includes the following features:

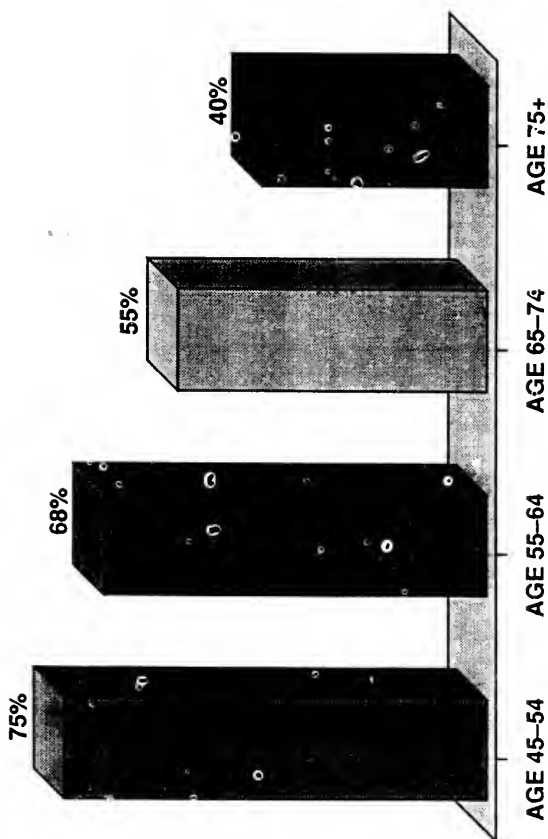
- o Prevention: The DUR program should include an on-line computerized prospective review of prescriptions at the point of purchase to immediately identify potential problems for the patient and to assure that prescribed medications are appropriate and will not cause adverse medical results (e.g., adverse drug-to-drug interactions).
- o Education and Enforcement: The DUR program should include an educational component that requires pharmacists to offer to counsel Medicare beneficiaries on proper use of their medications, potential side-effects, and any other potential problems. In addition, the DUR program should include a retrospective component that identifies inappropriate prescribing practices by physicians and provides feedback to physicians to encourage appropriate prescribing. The program should also identify patterns of fraud and abuse among physicians, pharmacists, and patients.
- o Standards: A National Commission on Drug Use Review should be established to set standards and criteria for DUR under the program. The Commission should include consumer representation.

Conclusion

AARP is a strong advocate of comprehensive health care reform that includes prescription drugs as a benefit for all Americans. We believe that any prescription drug benefit included under a reformed system must: 1) guarantee access to needed drug therapies; 2) contain cost effectively; 3) rely on stable, broad-based, and equitable financing; 4) provide for a parallel benefit structure across all ages; 5) protect low-income beneficiaries from exorbitant costs; and 6) encourage appropriate prescribing, monitoring, and use of medications.

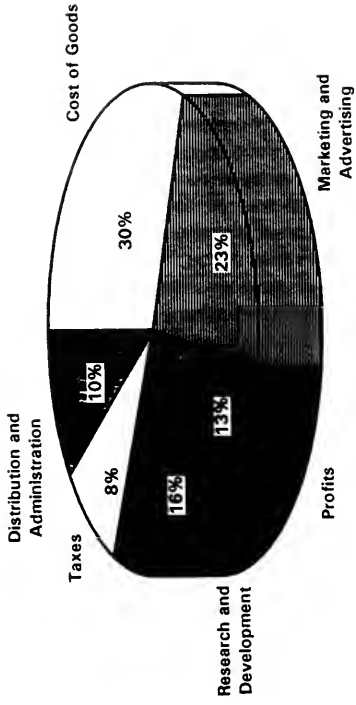
Thank you for giving AARP the opportunity to express its views on this important issue. We applaud the leadership of the Chairman and the other members of this subcommittee for your efforts to reform our health care system. We look forward to working with you to achieve passage of comprehensive health care reform legislation that includes a meaningful prescription drug benefit for all Americans.

Percent Having Prescription Drug Coverage



Source: "The Need for a Prescription Drug Benefit Under the Medicare Program," prepared for AARP by Chilton Research Services, June 1992.

Where the U.S. Prescription Dollar Goes (Manufacturers Component)



Chairman STARK. Martha, welcome back. Why don't you proceed?

STATEMENT OF MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. McSTEEN. Mr. Chairman and members of the Subcommittee on Health, as president of the National Committee to Preserve Social Security and Medicare, I can assure you that no other health care issue with the possible exception of long-term care so worries our most vulnerable seniors.

Any national plan to reform health care must include some coverage of prescription drugs for citizens of all ages. I would like to discuss four aspects of this important issue: need, cost containment, quality control and financing.

The high cost of prescription drugs is devastating to low and moderate income seniors. Although some national committee members have supplemental insurance that provides at least some coverage of prescription drugs, many have no such coverage at all.

I have received several hundred letters from national committee members recently who report prescription drug costs of up to \$100 a week. We have many members whose monthly prescription drug costs far exceed their Social Security benefits. The result as we have testified many times before is that these hard-pressed seniors are forced to make painful choices between medicines and heating oil or food just because of the cost. This is no way to live.

The National Committee believes that cost containment mechanisms must be built into any prescription drug benefit. We believe the pharmaceutical industry can and should voluntarily hold down prices. We think a prescription drug formulary is appropriate and think some kind of price monitoring and review mechanism should be established.

While prescription drug utilization review can help control cost, we think its real value lies in the potential for improving quality of care. For this reason, the National Committee believes that any plan to assure payment for prescription drugs must try to assure that noncompliance and misuse of medications are kept to a minimum.

According to the Institute of Medicine, one-third of all persons over 65 take at least 3 medications regularly. This is called polypharmacy and it indicates the potential for harmful interactions. Studies have reported that 10 to 17 percent or more of all hospital admissions of older patients are associated with medication problems. These medication related hospitalizations cost an estimated \$4.5 to \$7 billion annually, according to a 1989 study by the HHS Inspector General.

In light of all this, the National Committee would like to offer a suggestion. We would like to see funds earmarked for the kind of research recommended by the Institute of Medicine, large-scale studies of medication used in older populations, studies of the relationship of medication use to clinical outcomes, and studies in the ways in which the biological changes of aging affect older patients' responses to medications.

The National Committee supports broad-based financing for health care reform. As I have said many times, Medicare beneficiaries are willing to pay their fair share for health care reform

generally. Unfortunately, the House reconciliation legislation includes \$50 billion in Medicare cuts over a 5-year period for deficit reduction and the Senate Finance Committee would add an additional \$20 billion in cuts.

Any cuts in Medicare should be consistent with the yet-to-be-proposed health care reform plan and its cost containment provisions. In fact, any cuts in Medicare should be regarded as having been made in the name of health care reform.

The National Committee supports eliminating the wage base on the Medicare payroll tax, and of course we would have preferred that money be used for health care reform. We are opposed to financing prescription drug coverage through an extremely high, \$850 or over, deductible as it would provide little help to low and moderate income seniors. A much lower deductible with say a 50 percent copay instead of a 20 percent copay might even be preferable, especially if coupled with limits on total out of pocket costs.

The National Committee supports large increases in so-called sin taxes to finance health care reform. From our perspective, any evaluation and selection of financing options should be based on a total health care reform package, not on a prescription drug benefit alone.

Thank you for this opportunity to appear before you, Mr. Chairman.

[The prepared statement follows:]

National Committee to
Preserve Social Security
and Medicare



Statement of Martha McSteen
President
National Committee to Preserve Social Security and Medicare
Submitted to
Subcommittee on Health
House Committee on Ways and Means
Regarding
Health Care Reform and Prescription Drugs
June 22, 1993

Chairman Stark and members of the Subcommittee on Health:

It is indeed an honor to be here today to speak on behalf of older people who are having great difficulty finding a way to pay for necessary medicines prescribed by their physicians. As President of the National Committee to Preserve Social Security and Medicare, I can assure you that no other health care issue—with the possible exception of long term care—so worries our most vulnerable seniors.

This is why we feel so strongly that any national plan to reform health care must include some coverage of prescription drugs. Moreover, we believe that such coverage should be provided not just for seniors, but for citizens of all ages.

Prescription drug coverage already is a common feature of many health care plans offered by employers, and it is also provided under Medicaid. We do not like to see Medicare beneficiaries, who need this coverage most, excluded.

In my brief statement before you today, I would like to discuss four aspects of this important issue:

- Need
- Cost containment
- Quality control
- Financing

Need

The high cost of prescription drugs is devastating to low income and moderate-income seniors, and so these seniors are our greatest concern. Although some National Committee members have supplemental insurance that provides at least some coverage of prescription drugs, many have no such coverage at all. I have received several hundred letters from National Committee members who report prescription drug costs of up to \$100 a week. We have many members whose monthly prescription drug costs far exceed their social security benefits. The result, as we have testified many times before, is that these hard-pressed seniors are forced to make painful "choices" between medicines and heating oil, or medicines and food. Many of our members tell us that they cut down on their medications without telling their doctors they are doing so. This is no way to live, and it is the reason we feel so strongly about this issue.

Cost containment

The National Committee feels strongly that serious cost-containment mechanisms must be built into any prescription drug benefit. We think a combination of mechanisms may work best. The National Committee believes the pharmaceutical industry can and should voluntarily hold down prices. We think a prescription drug formulary is appropriate. We also think some kind of price monitoring and price review mechanism should be established. Above all, we do not want to see ever-increasing prescription drug price increases reflected in ever-increasing premiums.

Quality Control

While prescription drug utilization review can help control costs, we think its real value lies in the potential for improving the quality of care. For this reason, the National Committee believes that any plan to assure payment for prescription drugs must try to assure that non-compliance and misuse of medications are kept to a minimum. As you know, seniors need to take more medications than younger people, and they may take them in potentially dangerous combinations. Physically, seniors tend to respond to medications differently than younger people.

According to the Institute of Medicine, one-third of all persons over 65 take at least three medications regularly. This phenomenon is called "polypharmacy," and it indicates at least the potential for harmful interactions. In fact, various studies have reported that 10 to 17 percent or more of all hospital admissions of older patients are associated with medication problems. These

medication-related hospitalizations cost an estimated \$4.5 to \$7 billion annually, according to a 1989 study by the Inspector General for the U.S. Department of Health and Human Services. Clearly, anything that can be done to assure appropriate prescribing by physicians and appropriate use of medications by patients can save unnecessary hospital costs and improve the quality of life of older people.

In light of all this, the National Committee would like to offer two suggestions: First, we would like to see an effective prescription drug utilization review program that would flag potential adverse reactions and alert both physicians and patients. Second, we would like to see funds earmarked for the kinds of research recommended by the Institute of Medicine: Large-scale studies of medication use in older populations, studies of the relationship of medication use to clinical outcomes, and studies of the ways in which the biological changes of aging affect older patients' responses to medications.

Financing

The National Committee supports broad-based financing for health care reform. As I have said many times, Medicare beneficiaries are willing to pay their fair share—for prescription drug coverage, or for health care reform generally.

Unfortunately, the House reconciliation legislation includes \$50 billion in Medicare cuts over a five-year period for deficit reduction. And the Senate Finance Committee would add an additional \$20 billion in cuts. This is premature. Any cuts in Medicare should be consistent with the yet-to-be-proposed health care reform plan and its cost containment provisions. In fact, any cuts in Medicare should be regarded as having been made in the name of health care reform.

The National Committee supports eliminating the wage base on the Medicare payroll tax and using that money for health care reform. Such a proposal, which would raise \$29.2 billion over five years, is also part of the reconciliation package, even though revenues are dedicated to the Medicare Hospital Insurance Trust Fund.

The National Committee is opposed to financing prescription drug coverage through an extremely high (\$850 or over) deductible. While a high deductible would help reduce the cost of the prescription drug benefit, it would provide little help to low-income and moderate-income seniors. A much lower deductible, with a 50 percent co-pay instead of a 20 percent co-pay, might be preferable—especially if it were coupled with limits on total out-of-pocket costs.

The National Committee supports large increases in so-called sin taxes (including a \$2-per-pack "monster" cigarette tax) to finance health care reform.

From our perspective, any evaluation and selection of financing options should be based on the total health care reform package, not on a prescription drug benefit alone.

Chairman STARK. Well, just for openers, we reintroduced in H.R. 200 for a talking position pretty much the same pharmaceutical benefit as we had in the ill-fated catastrophic bill.

Ms. McSTEEN, you opposed that or pushed for its repeal. In any drug benefit that we might do in health reform, integrated into Medicare, it could very well replace coverage that many seniors now have under their medigap policies. Most buy it from AARP sold by Prudential.

What are we going to do this time for you and your group to support the pharmaceutical benefit?

Ms. McSTEEN. You remember, Mr. Chairman, we opposed the catastrophic package because it in fact was not truly what most people considered catastrophic coverage, that is, long-term care for a long period of time.

Chairman STARK. Nobody ever said it was supposed to be.

Ms. McSTEEN. It was interpreted by many individuals as that. We were not opposed to the prescription drug portion by itself.

Chairman STARK. Let's stop there. So if we did the same thing over again you would not oppose the prescription drug part?

Ms. McSTEEN. That is right.

Chairman STARK. I thought I would ask you while you were here. A witness later today will suggest that the pharmaceutical manufacturing groups in mysterious ways use front organizations to try and destroy legislation, including organizations created to represent the elderly.

Now, Ms. Canja, has the AARP ever taken any money from the pharmaceutical manufacturers or done any lobbying at their behest?

Ms. CANJA. Not to my knowledge.

Chairman STARK. How about you, Ms. McSTEEN?

Ms. McSTEEN. None.

Chairman STARK. Maybe this guy is wrong. I wanted to make sure we had that on the record.

What does AARP say about supporting a bill similar, with the benefits and the costs and the deductibles similar to what we had in H.R. 200? You might like something better, but would you object to a benefit in that form?

Ms. CANJA. The times have changed since the Catastrophic Care Act and we are finding that people are having such difficulty right now getting insurance coverage and are paying such high costs out of pocket that they are beginning to feel the need for help.

We have done surveys and found 70 percent now would say they would be willing to pay for it; they need it that badly.

Chairman STARK. What does your medigap policy—you only have one that includes drug benefits out of the ten?

Ms. CANJA. We offer all 10 policies in every place. Only the last three, the most costly ones have the drug benefit.

Chairman STARK. What is the lowest price of those that include drug benefit per month?

Ms. CANJA. I can't tell you because it varies from State to State.

Chairman STARK. Roughly.

Ms. CANJA. I can't tell you even that.

Chairman STARK. Do you pay 700 and change?

Ms. CANJA. More than that. So the timing is different. People really need the coverage now. They cannot afford it.

I gave the example of my mother. Ms. McSteen mentioned other higher costs. This is a very difficult time for people that need medication that are older.

Chairman STARK. Your testimony suggests that a voluntary effort of the drug manufacturers isn't working to control outpatient drug prices and you think we should consider other types of policies.

Ms. CANJA. We suggest that there are many mechanisms you might consider, including direct price controls.

Chairman STARK. How would you feel about that?

Ms. MCSTEEN. I think we have to look and see exactly what that benefit is going to be and who is willing to pay for that.

Chairman STARK. I am talking about just price controls now.

Ms. MCSTEEN. I think there are other ways of achieving the same thing. We were suggesting a price review board. That doesn't necessarily—

Chairman STARK. Like Canada has?

Ms. MCSTEEN. Yes, somewhat similar to that.

Chairman STARK. I don't mind that. That is a little more Draconian, so that is great. The Canadian price review has been very effective. But I am not so sure that wouldn't be harder to pass. So you would support stringent price review and control?

Ms. MCSTEEN. First of all, I think we have to offer the pharmaceuticals the opportunity of voluntarily controlling price and then as I suggested, there should be a formulary—

Chairman STARK. You think that voluntary price controls might work?

Ms. MCSTEEN. I do if there is a formulary and the price of the drugs are listed and reviewed. I think there has to be some sort of peer review, whether you call it peer review or utilization review, to assure that the prices are reasonable.

Chairman STARK. Do you know of any other instance in which voluntary price controls have worked?

Ms. MCSTEEN. Well, with as much attention as is being focused on the pharmaceuticals these days, there should be a willingness to at least try and some are trying voluntary controls. I don't think that alone has been demonstrated, no.

Chairman STARK. We have had that since 1981.

Ms. MCSTEEN. Well, alone it has not worked, I agree.

Chairman STARK. It hasn't worked for the hospitals or doctors; has it?

Ms. MCSTEEN. No.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Just a brief followup question. As the Congress and the administration work together and then as the Congress begins to work on a bill, one of the issues will be the one that Mr. Stark has been raising.

As we expand coverage, there is going to be more of a pressure on what it will cost and what will be the financial ramifications of it. So if we dramatically expand prescription drug coverage, there will be more of a premium on what it all is going to cost; right?

Let me just ask from the point of view of each of your organizations, how do you envisage participating in this process? From the testimony of both of your organizations, in a way you don't respond to the toughest question. The toughest question is going to be whether we ought to let the market work with review processes of various kinds or whether perhaps on an interim basis there will need to be some kind of control over prices.

Now, I don't think either of your organizations has really a stand on that issue; right?

Ms. MCSTEEN. That is right.

Ms. CANJA. We don't have a direct stand on that, but AARP has developed a health care plan of its own called Health Care America and they looked very carefully at cost containment and what the prices would be, how it would be financed. So they have a great deal of information and material they may have shared with you. If not, it will be shared with you.

They did have a drug benefit included in their package.

Mr. LEVIN. Right, but at some point people have to push a red or green button and you can't have 218 people voting yellow. So seriously, at some point the administration is going to have to step up finally to this issue, and I think they are attacking these issues intensively. But at some point it will have to make a decision in terms of its proposal and the Congress will.

Do you anticipate that your organizations will at some point reach some kind of a conclusion on how we handle the cost issue?

Ms. CANJA. We have to look at what goes into that cost issue, at what is being offered, at what you are asking. Are you asking copays, deductibles? Is it fair? Is the financing fair?

One of the basic problems in the past was that the financing was not considered fair. The other thing that was very important was there wasn't cost containment so costs were escalating and people were very much afraid of that. So you have to look at the whole package. Do you have good cost containment in there?

Mr. LEVIN. The question is how we achieve cost containment.

Ms. CANJA. I think that AARP has been working with the administration and with Congress providing input. As we get to those hard questions they would still be providing input.

Mr. LEVIN. How about a recommendation?

Ms. CANJA. Recommendations also. What is the question?

Mr. LEVIN. I am not saying this critically. I am just saying it analytically, that at some point everybody has to kind of say what they really feel, or they don't have to, but the administration will and Members of Congress will.

Ms. McSteen, in terms of your organization, I think fairly stated, reading both of your organizations' statements on cost containment, you could not write a bill based on that material, because it is iffy.

In your statement on page 2, Ms. McSteen, you indicate you think a combination of mechanisms may work best, and then you talk about voluntarily holding down prices, a drug formulary is appropriate, some kind of price monitoring and price review mechanism should be established. "Some kind" we both know but you can't write legislation in that manner.

I am not saying that critically. I am just asking you whether you think in the next few months your organizations are likely to come

to a conclusion on more precisely what kind of cost containment should be adopted or recommended by the President and adopted by the Congress?

Ms. MCSTEEN. We anticipate coming forward with recommendations. We are again surveying our members with specific questions about prescription drug coverage and how much they pay a month now and what they would be willing to pay for coverage, so I would hope we would have more information. Certainly this testimony did not address how you would enter it into legislation. But we are certainly willing to sit down and talk or do more work on it because I think as much as we can do to be cooperative with the pharmaceutical industry, the better we will be, because I know from past experience that regulation and regulation and regulation is very expensive and it slows down a process most of the time.

We are very interested in the multiple uses of prescription and over-the-counter drugs and I think you know from the testimony that that not only affects the cost but it also affects the quality of life, and we too often overlook that.

Mr. LEVIN. My time is up. Maybe it is best left at that.

Thank you.

Chairman STARK. Mr. Brewster.

Mr. BREWSTER. Thank you, Mr. Chairman. There has been testimony earlier that managed competition has lowered cost in particular areas.

Ms. McSteen, what percentage of your members would be in some kind of managed competition plan? Do you have any idea of that?

Ms. MCSTEEN. Very few are in plans now, that is, HMOs, simply because HMOs do not offer seniors that opportunity. So your question is very pertinent. But unfortunately we don't have the experience that we can say absolutely this is what could happen or would happen.

Mr. BREWSTER. The managed competition plans mainly cover younger people who are less likely to be sick or need health care and your people in general are the ones who catch the highest prices on pharmaceutical products and highest cost of health care costs, while they are the people who generally need health care the most?

Ms. MCSTEEN. Yes. They have to have it in order to survive.

Mr. BREWSTER. So in this case if there is a cost shifting going on because someone gets an extraordinarily low price and someone else gets a higher price, your people are generally being subjected to the higher price?

Ms. MCSTEEN. Generally.

Mr. BREWSTER. You mentioned that pharmaceutical products should be in a formulary with reasonable prices. What is reasonable and how do you determine that?

Ms. MCSTEEN. I think you would have to go to the profession and to the physicians themselves and the pharmacists and say what is reasonable. Is it the cost to Medicaid or to the veterans administration or is it middle of the road or is it generic drugs?

I think reasonable has to take into account the very low and the very high and try to find something that all parties can live with.

Mr. BREWSTER. So if a product is being sold to one group for 8 cents a tablet and another for 44 cents a tablet, maybe 26 or 27 cents a tablet would be reasonable for all?

Ms. MCSTEEN. Yes, sir.

Mr. BREWSTER. I notice your far different testimonies on financing for a national health care plan.

Ms. Canja, you say that in your opinion it is important that it be broad based; that it be consistent financing.

Ms. McSteen, the only thing I see in financing here is a "\$2-per-pack monster cigarette tax".

Would that not be a declining tax base, and how can you set a long-term health care plan on an unstable tax base that is declining now and will decline much greater with that kind of tax?

Ms. MCSTEEN. That is addressing just the coverage for pharmaceuticals or prescriptions. The whole health care reform has to be addressed, and I agree that it has to be broad based. We have always said that. We know that the sin taxes are out there and available and unfortunately many of the taxes in the current domestic budget plan I would have diverted to health care reform.

For example, lifting the wage base for Medicare tax in my opinion would have been much more appropriately diverted to the health care reform bill.

Mr. BREWSTER. I notice both of you two have mentioned DURs, especially you Ms. Canja, in your testimony. I believe that DURs can be very helpful in containing costs. But much more than that, I believe it can provide much better quality of life, much more appropriate medication usage.

And I am glad to see that the Chairman has worked on electronic, on-line DURs which, as you know, many of your constituents and my constituents, especially elderly people, may go to multiple doctors, may use multiple pharmacies, and with that, some mechanism of someone knowing the different medications, the contraindications, and the problems in concurrent usage.

You have a lot of inappropriate care today, even though everybody is doing the best they can to provide good care. Though I am glad to see that you are both supportive of expanded DURs, electronic on-line DURs, and also from a pharmacist's standpoint, the consultant value of the retail pharmacist to your constituents. I think that is extremely important as we proceed toward some kind of a health care plan.

I have enjoyed your testimony. Thank you.

Mr. STARK. I thank you both. I did want to ask Ms. McSteen, you mentioned, I think in response to Mr. Brewster's question, that your members are not often in managed care plan—

Ms. MCSTEEN. Settings.

Mr. STARK. Why did you say that was the case?

Ms. MCSTEEN. Because in most parts of the country—it is not true in California—but in most parts of the country, HMOs have not opened the doors to seniors for the very reasons that you have mentioned, that they are more expensive. They use the system more often, and they use prescription drugs more.

Mr. STARK. Now at AARP you have open enrollment?

Ms. CANJA. Yes, they do.

Mr. STARK. So I could drop Blue Cross and join yours?

Ms. CANJA. Yes.

Mr. STARK. So it is just a question of the managed care of the HMOs that are not risk contractors, and you would have to be in that when you turned 65; you couldn't join it later unless they accepted a risk contract?

Ms. MCSTEEN. One problem that seniors have had with HMOs has been the lack of choice of physician. And our members certainly are saying, you know, we want to be able to go to our own physician. And if that can be a part of the managed competition, then I think that would make a big difference.

Mr. STARK. Have any of you had any experience—or has your membership commented on what has been referred to as Medicare select? It is kind of a hybrid where you buy a medigap policy but, in effect, you have to buy a nonrisk contract; you have to join the underlying capitated Medicare plan, plus use the supplemental or medigap, all for one fee. Have either of you——

Ms. CANJA. It is in Florida, but I am not familiar with it.

Ms. MCSTEEN. Nor am I.

Mr. STARK. Thank you both very much for your testimony.

Mr. BREWSTER. Mr. Chairman, could I?

Mr. STARK. I am sorry. Mr. Brewster.

Mr. BREWSTER. You made a point there, choice of physician. I think some of us feel that the choice of provider should be very important to all people, regardless of age or whatever.

I notice some of the plans out today are exclusive with some physicians and some pharmacy providers, et cetera, and don't allow choice of provider.

In your opinion, is there anything wrong with a plan setting whatever fees they are going to reimburse, if it is \$20 a doctor visit or \$4 a prescription or whatever and then allowing every provider to participate that wants to?

Ms. MCSTEEN. That sounds like the best of all worlds, if that happened.

Mr. BREWSTER. That would allow your people, your constituents, the right to use whatever provider they want and allow the cost containment that the company should be looking for that they are trying to achieve; is that correct?

Ms. MCSTEEN. Well, yes. It is my understanding that we will move in that direction depending on the size of the competition geographically.

Mr. BREWSTER. Thank you.

Mr. STARK. Thank both of the witnesses.

Mr. STARK. Our next witnesses included representatives from four organizations representing pharmacy providers and drug manufacturers.

We are pleased to welcome Gerald Mossinghoff, who is president of the Pharmaceutical Manufacturers Association; William F. Haddad, chairman of the Generic Pharmaceutical Industry Association; Timothy Webster, representing the Coalition for Consumer Access to Pharmaceutical Care. Webster is accompanied by Linda Golodner. And Robert A. Waspe, representing the Community Retail Pharmacy Health Care Reform Coalition. He is accompanied by John Rector.

We welcome all of you to the subcommittee. I hope we have room for all of you at the table. If we are a little crowded, we will ask the accompanies to slide back a notch. I would ask you do proceed to summarize or expand on your statements orally in the order that I read your names.

And, Mr. Mossinghoff, why don't you lead off.

**STATEMENT OF GERALD J. MOSSINGHOFF, PRESIDENT,
PHARMACEUTICAL MANUFACTURERS ASSOCIATION**

Mr. MOSSINGHOFF. Thank you, Mr. Chairman. I will address the subject of a Medicare drug benefit within the context of the Pharmaceutical Manufacturers Association's overall position on health care reform.

The pharmaceutical industry supports comprehensive health care reform, including a prescription drug benefit for every American. Health care reform should take an appropriate managed competition approach. Such an approach would create consumer choice among providers competing in an efficiently organized health care delivery system. It would rely on market forces to contain costs, ensure access, preserve quality of care and stimulate innovation.

Prescription medicines should be included as part of the standard benefit package under managed competition. Although pharmaceuticals are among the most cost-effective therapies, more than half of prescription drug expenditures now are paid for by the patient out of pocket.

Different copays and deductible criteria for prescription drugs could buy us treatment for more costly alternatives. Therefore, as a general matter, prescription drugs should be subject to the same copay and deductible requirements as all other health care services provided in the standard benefits package.

Medicaid should be folded into the managed competition system. However, if Medicaid is to remain freestanding, prescription drug coverage should be provided for Medicaid patients up to at least 100 percent of the federally defined poverty level. On average, the States now only provide benefits to 40 percent of those with incomes below the poverty line.

There should be an outpatient prescription drug benefit for Medicare beneficiaries. Older Americans, who need the medicines most, are least likely to have prescription drug coverage.

The Medicare benefit should be provided in the managed competition setting. This is not possible in the near term, incentives should be developed for Medicare patients to obtain drug benefits through existing managed care programs. If that, in turn, is not possible, an adequately funded outpatient prescription drug benefit should be designed under part B.

Competitive market pressures and voluntary industry action already are restraining price increases and will effectively contain costs during the transition to a reformed system. These market pressures will be even stronger once managed competition systems are adopted at the Federal and State levels.

A quote from the Boston Consulting Group in a comprehensive report in April indicates that managed care grew explosively in the 1980s. At the start of the decade, only 5 percent of the insured population was enrolled in managed care programs influencing a small

fraction of the drug market. Currently, approximately 80 percent of the insured population is influenced in one way or another by managed care, as is more than 50 percent of the drug market. Some projections suggest that 90 percent of the drug market will be under the influence of managed care by the year 2000.

The generic drug share of the market has also increased enormously. More than 50 percent of all new prescriptions in the United States are expected to be dispensed using a generic substitution by 1995. And the rapid expansion of industry research and development capability means that even breakthrough drugs now face stiff competition from innovative products long before their patents expire and generic competition begins.

Again, the Boston Consulting Group found that prices for new products approved and launched during 1991-92, a 2-year period, were, on average, 14 percent lower than the leading product in the same therapeutic category.

During the transition to a reformed health care system, the industry is doing its part to control costs. Seventeen PMA companies, representing about two-thirds of the U.S. market for prescription medicines, individually and independently, have announced that they will keep their price increases at or below the general inflation rate. And they are honoring their pledges.

At the unanimous request of the PMA board of directors in December, I recommended to the Clinton administration that it urge all companies to make such pledges. And in March, PMA asked the Justice Department for permission to discuss a voluntary plan with enforcement provisions under which participating companies would keep their price increases at or below the general inflation rate.

Under our plan, company performance would be reviewed by the U.S. General Accounting Office. The Justice Department has not yet responded to our proposal.

The result of increased market pressures and voluntary industry restraint is dramatic. As shown in the figure to my left and as shown in figure 1 of my statement, the increase in the consumer price index for prescription drugs was virtually the same during the 12-month period, May 1992 to May 1993, as the consumer price index for all items, 3.3 percent for drugs compared to 3.2 percent—

Mr. STARK. What was the manufacturer's price increase in that same period?

Mr. MOSSINGHOFF. May to May was somewhere over 4, 4.4 percent.

Mr. STARK. Four point nine percent.

Mr. MOSSINGHOFF. May, I think, is—

Mr. STARK. Isn't that a more relevant price increase? Are you kind of gilding the lily with that? Six hundred products—if you use 20 of the most recently purchased, which I think most economists would say is not—is a fair comparison.

Mr. MOSSINGHOFF. I read your statement, Mr. Chairman, in the Congressional Record. We agree with you that there are problems with the way the Bureau of Labor Statistics determines these.

One of the great advantages that the plan that we have submitted to the Department of Justice—and we have discussed it with Mr. Magaziner and officials in the Clinton administration—

Mr. STARK. That must have been fascinating.

Mr. MOSSINGHOFF. One of the advantages of the proposal that we would like to implement would be that, instead of requiring or using samples which vary, I think it is constant for a given pharmacy over a 5-year period, but at some point it is determined on a random basis. As you pointed out, we could give you, through the General Accounting Office, actual price data that would be audited from each of the companies at PMA. There is a great advantage.

We talked to the Bureau of Labor Statistics about their methods, and they are looking at changing those. But the advantage—we see it going across the board—is we wouldn't have to use a sample. We could give you, through the General Accounting Office every year, exact data, audited data by one of the accounting firms to be audited further by the General Accounting Office. We could give you exact data. That is one of the advantages of the voluntary proposal that we submitted to the Department of Justice.

The companies can't sit around a table now and discuss the details. Everyone is doing this independently, and they must do that under the antitrust laws. If the government got involved in jawboning, that would take care of that antitrust situation, or if the Justice Department would give us an affirmative response to our request for this business review letter.

But I would say, if it is unfair to compare CPIs, then a lot of our sharpest critics have been pretty unfair over the last several years. That is what I get hit with when I come up and testify before various committees.

Finally, Mr. Chairman, I will end my statement with just a caution. There was a lot of talk here about price control boards, price review boards, price setting mechanisms, something you could refer to as a public utility model. It seems to me Congress ought to be very, very careful about changing our industry into a public utility. We are, by all accounts, by every measure, the most competitive, high technology United States industry in the world. And I think the Congress and the administration ought to be very cognizant of that.

Moreover, this discussion has real effect. As pointed out in the Wall Street Journal just this past May 25, ever since the administration started talking about health care changes, the fear of price controls has hurt the biotechnology business. A quote from the Wall Street Journal states, "Stock prices of biotech companies have plummeted. Financing has dried up and plans for expansion, including hiring, new construction and new projects have been put on hold." That is an analysis done in the Wall Street Journal.

Finally, in concluding in the interest of time, let me just point out, as I have in my prepared statement, on a matter of critical importance to the design of any properly funded drug benefit for the elderly, the subcommittee press release significantly understates in our view the average annual cost of prescription drugs per elderly person in 1993. The figure cited in the press release is \$371. The Office of the Actuary at HCFA estimates that they will spend \$525 a person per year on prescriptions in 1993, and Mr. Vladeck indicated for the Medicaid patients, the elderly, that the number is \$760.

As you recall, the major difficulty we had with respect to the House-passed version of the catastrophic bill was it was underfunded right from the start because of estimates. And we would urge you to take in these later, and we think much more accurate estimates, in the design of any system under Medicare or otherwise.

Mr. Chairman, that concludes the summary of my statement.
[The prepared statement follows:]

Statement

**Pharmaceutical
Manufacturers
Association**

GERALD J. MOSSINGHOFF
PRESIDENT
PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

JUNE 22, 1993

Mr. Chairman and Members of the Subcommittee:

I am Gerald J. Mossinghoff, President of the Pharmaceutical Manufacturers Association. PMA represents more than 100 research-based pharmaceutical companies -- including more than 30 of the country's leading biotechnology companies -- that discover, develop and produce most of the prescription drugs used in the United States and a substantial portion of the medicines used abroad. I appreciate the opportunity to appear today at this hearing to consider the adoption of an outpatient Medicare drug benefit as part of healthcare reform.

I will address the subject of a Medicare drug benefit within the context of PMA's overall position on healthcare reform.

The research-based pharmaceutical industry supports comprehensive healthcare reform, including a prescription-drug benefit for every American.

Healthcare reform should take an appropriate "managed-competition" approach. Such an approach would create consumer choice among providers competing in an efficiently organized healthcare-delivery system. It would rely on market forces to contain costs, ensure access, preserve quality of care and stimulate innovation.

Prescription medicines should be included as part of the standard-benefit package under managed competition. Although pharmaceuticals are one of the most cost-effective therapies, more than half of prescription-drug expenditures now are paid by the patient out-of-pocket.

Different co-pay and deductible criteria for prescription drugs could bias treatment to more costly alternatives. Therefore, prescription drugs should be subject to the same co-pay and deductible requirements as all other healthcare services provided in the standard-benefit package.

Medicaid should be folded into the managed-competition system. However, if Medicaid is to remain free-standing, prescription-drug coverage should be provided for Medicaid patients up to at least 100 percent of the Federally defined poverty level. On average, the states now only provide benefits for 40 percent of those with incomes below the poverty level.

There should be an outpatient prescription-drug benefit for Medicare beneficiaries. Older Americans need medicines the most, but are least likely to have prescription-drug coverage.

The Medicare benefit should be provided in a managed-competition setting. If this is not possible in the near-term, incentives should be developed for Medicare patients to obtain drug benefits through existing managed-care programs. If that is impossible, an adequately funded outpatient prescription-drug benefit should be designed under Medicare Part B.

Competitive market pressures and voluntary industry action already are restraining price increases and will effectively contain costs during the transition to a reformed system. These market pressures will be even stronger once managed-competition systems are adopted at the Federal and state levels.

"Managed care grew explosively in the 1980s," The Boston Consulting Group reported in an April 1993 study of the pharmaceutical market. "At the start of the decade, only 5 percent of the insured population was enrolled in managed care programs, influencing a small fraction of the drug market. Currently, approximately 80 percent of the insured population is influenced in some way by managed care, as is more than 50 percent of drug market volume. Some projections suggest that 90 percent of the drug market will be under the influence of managed care by the year 2000."

The generic-drug share of the market has increased enormously. More than 50 percent of all new prescriptions in the U.S. are expected to be dispensed using a generic substitute by 1995. And the rapid expansion of industry research and development capability means that even breakthrough drugs now face competition from innovative products long before their patents expire and generic competition begins. The Boston Consulting Group found that prices for new products approved and launched during 1991-1992 were on average 14 percent lower than the leading product in the same therapeutic category.

During the transition to a reformed healthcare system, the industry is doing its part to control costs. Seventeen PMA companies, representing about two-thirds of the U.S. market for prescription medicines, individually have announced that they will keep their price increases at or below the inflation rate -- and they are honoring their pledges. At the unanimous request of the PMA Board of Directors in December, I recommended to the Clinton Administration that it urge all companies to make such pledges. And in March, PMA asked the Justice Department for permission to discuss a voluntary plan with enforcement provisions under which participating companies would keep their price increases at or below the inflation rate. Under our plan, company performance would be reviewed by the U.S. General Accounting Office. The Justice Department has not yet responded to our proposal.

The result of increased market pressures and voluntary industry restraint is dramatic. As shown in Figure 1 below, drug-price increases have slowed substantially during the 1990s. And, for the most recent 12-month period through May 1993, the increase in the Consumer Price Index for prescription drugs was virtually the same as the increase in the Consumer Price Index for all items -- 3.3 percent for drugs compared to 3.2 percent for all items.

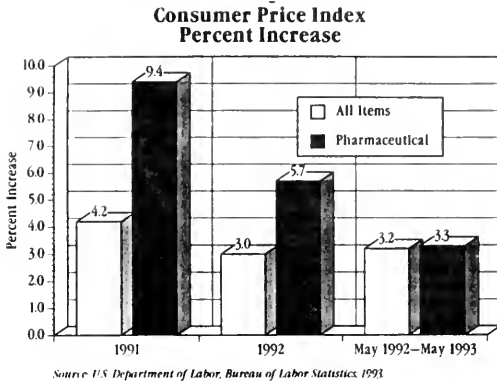


Figure 1.

In general, any healthcare-reform plan must do at least four things -- control costs, increase access, maintain quality and stimulate innovation.

Drugs are a major part of the solution to controlling healthcare costs. They not only save lives -- they save money. They keep patients out of hospitals, out of emergency rooms and out of nursing homes, thus reducing treatment costs.

Drugs are not the cause of the country's healthcare crisis. As shown in Figure 2 below, healthcare expenditures as a percentage of Gross Domestic Product (GDP) have increased significantly since 1965 -- but drug costs have remained relatively constant at about one-half of 1 percent of GDP.

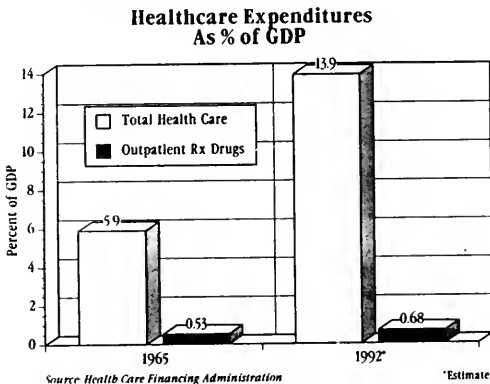


Figure 2.

Healthcare reform must ensure that every American has healthcare coverage. Of those age 64 to 74, 45 percent do not have prescription-drug coverage. And of those 75 and older, 60 percent lack such coverage.

Healthcare reform also must preserve quality of care. Among other things, this means using sound scientific data, valid outcomes measurements, an open decision-making process, access to all therapies approved by the Food and Drug Administration, physician flexibility in selecting therapies and informed patient choice. It also means using drug use review. The American Medical Association, the American Pharmaceutical Association and

PMA prepared a joint publication -- Principles of Drug Use Review -- that is a guide for policymakers in shaping principles for appropriate treatments.

Finally, healthcare reform must maintain the incentives for innovation. The most important way to ensure quality, cost-effectiveness and affordability in healthcare is to encourage innovation.

The U.S. industry leads the world in pharmaceutical innovation -- and is one of the country's most internationally competitive industries -- because of its huge investments in research and development and the impressive productivity of that R&D. Unlike many other U.S. industries, which are cutting their R&D expenditures, the pharmaceutical industry continues to increase its investments in research and development exponentially. The industry has doubled its R&D expenditures every five years since 1970. This year, the industry will spend \$12.6 billion on R&D -- a 13.5 percent increase over 1992. The industry will spend 16.7 percent of its sales on research and development in 1993 -- compared to an average of 3.6 percent for all industries engaged in R&D.

As shown in the table below, the costs of only eight diseases that afflict older Americans -- osteoporosis, diabetes, stroke, depression, arthritis, Alzheimer's, cancer and cardiovascular disease -- amount to a staggering total of \$431 billion a year. The research-based pharmaceutical industry has 298 medicines in human clinical trials or awaiting approval at the FDA for just these eight diseases.

**Uncured Diseases:
Costs and Promising Medicines**

Disease	Annual U.S. Cost in Billions	Source of Cost Estimate	New Drugs in Development
Alzheimer's	\$90	Alzheimer's Association	19
Arthritis	\$35	Arthritis Foundation	20
Cancer	\$104	National Cancer Institute	124
Cardiovascular	\$117	American Heart Association	78
Depression	\$50	National Institute of Mental Health	12
Diabetes	\$20	American Diabetes Association	13
Osteoporosis	\$10	National Institute on Aging	20
Stroke	\$25	National Stroke Association	12

While PMA supports an appropriate managed-competition approach to healthcare reform, we strongly oppose Government price regulation, standby regulation and creation of a National Drug Price Review Board. Government regulation of the pharmaceutical market is totally unnecessary and would have extremely adverse effects.

As stated in an editorial in the April 2, 1993 issue of *Science*, "The major casualties of excessive price pressure on drugs would be the small biotechnology companies, the rate of development of new drugs to relieve human suffering, and global leadership of the United States in creating new pharmaceuticals."

Price regulation of medicines would stifle the development of innovative, cost-effective medicines by biasing pharmaceutical research toward low-risk, low-benefit new products. Regulation of new-product prices would have a particularly severe impact on our biotechnology companies -- which have been among the country's most promising in the high-technology field. In fact,

the threat of price regulation already has had such an impact.

"Ever since the administration started talking about health-care changes, the fear of price and cost controls has hurt the biotech business," The Wall Street Journal reported on May 25, 1993. "On Wall Street, stock prices of biotech companies have plummeted. Financing has dried up. And plans for expansion, including hiring, new construction and new projects, have been put on hold."

In a 1991 study of the international competitiveness of America's pharmaceutical research industry, the U.S. International Trade Commission (ITC) stated that a major reason the industry has long led the world in pharmaceutical innovation is that the United States "has not to date implemented price controls on pharmaceuticals."

Studies have shown that, in countries that regulate prescription-drug prices such as Japan, France and Italy, pharmaceutical innovation has suffered severely and very few important new drugs have been developed. "Several countries that have implemented such programs [cost-containment programs, price controls or both] have seen their pharmaceutical industries weaken or shift outside their borders," the ITC stated.

PMA also strongly opposes restrictive Government formularies, prior-approval requirements and therapeutic substitution. A restrictive Government formulary limits the FDA-approved medicines that a physician may prescribe for patients. Prior-approval systems require that a physician obtain permission from a Government official before the physician may prescribe a particular medicine for a particular patient. Therapeutic substitution would allow a patient to be switched to a chemically different drug than the one prescribed by the patient's physician without the physician's approval.

Restrictive Government formularies, prior approval and therapeutic substitution all limit a physician's ability to individualize each patient's therapy. This is bad medicine -- patients respond in different ways to different drugs. As Mrs. Clinton told the American Medical Association on June 13, "...it is and remains a mystery to me how a person sitting at a computer in some air-conditioned office, thousands of miles away, can make a judgment about what should or shouldn't happen at a patient's bedside in Illinois or Georgia or California."

Restrictive Government formularies, prior approval and therapeutic substitution are also penny-wise and pound-foolish. Academic studies show that such procedures might save money on drugs -- but they also increase expenditures for other, more expensive medical services. A better way to restrain costs, without jeopardizing quality of care, is to assure that appropriate use of pharmaceuticals as set forth in the joint Principles of Drug Use Review mentioned earlier.

As stated at the outset of my testimony, PMA has previously supported an outpatient drug benefit under Medicare. While we opposed the House version of the Medicare Catastrophic Coverage Act of 1988 because we believed it would have been inadequately funded from the start, we worked with the Senate on a bill that had built-in safeguards. These included (1) prohibition of a formulary, (2) Secretarial authority to adjust the deductible in light of program experience and (3) provision of more adequate financial reserves. We supported the drug provisions of the Senate-passed bill in the House-Senate Conference Committee, which adopted the essential features of the Senate version. And we urged then-President Reagan to sign the final legislation, which he did on July 1, 1988.

As the Subcommittee well knows, Congress repealed the

Catastrophic program in late 1989 in response to complaints from Medicare beneficiaries that they had to pay the entire costs of the new benefits. Now there is a chance to take a fresh look at this very important issue within an appropriate managed-competition approach to healthcare reform.

Before I end my Statement, I will address a few statements and statistics set forth in the Subcommittee's press release announcing this hearing.

According to the press release, the Office of Technology Assessment (OTA) reported that the pharmaceutical industry has been earning profits beyond what is needed "to pay for its debt from research and development."

"Pharmaceutical R&D is a risky investment," the OTA stated in its February 1993 report. "Therefore, high financial returns are necessary to induce companies to invest in researching new chemical entities."

The OTA study focuses in large part on drugs approved by FDA in the early 1980s, and on market conditions and industry practices at that time. Because conditions have changed drastically, the study is not relevant to the current market situation. "The cost of bringing a new drug to market is very sensitive to changes in science and technology, shifts in the kinds of drugs under development and changes in the regulatory environment," the OTA stated. "All of these changes are occurring fast." (Emphasis added.) Consequently, the OTA concluded, it is impossible to predict conditions in the 1990s.

The pharmaceutical industry is in a totally different environment today than it was during the 1980s. The most dramatic changes have been the explosive growth of managed-care programs -- with their cost-containment leverage -- and the growth of generic competition.

The Subcommittee press release also states that the General Accounting Office (GAO) has documented that the prices of many drugs have exceeded the rate of general inflation. Again, that was yesterday's news. Today's story is entirely different.

Increased market pressures and voluntary industry action have led to a significant slowdown in prescription-drug price increases, as depicted earlier in Figure 1. Drug-price inflation and general inflation are now the same.

The Subcommittee press release further refers to the September 1992 GAO report that concluded that the prices of prescription drugs were considerably higher in the United States than in Canada. Subsequent independent studies noted that there are many methodological flaws in the study. For one thing, the study compared apples and oranges -- the lowest discounted price in Canada with the published or "sticker" price for U.S. medicines, which does not reflect discounts and rebates.

Further, in 1969, Canada adopted a system that kept drug prices low -- at the expense of pharmaceutical innovation. Since that time, Canada has developed virtually no new drugs while the United States has led the world in discovering and developing new drugs. To spur pharmaceutical innovation, Canada changed its law in 1988 and again earlier this year to make it more consistent with the laws of the United States and other industrialized countries.

On a matter of critical importance to the design of a properly funded drug benefit for the elderly, the Subcommittee press release significantly understates the average annual cost of prescription drugs per elderly person in 1993. The figure cited in the press release is \$371. The Office of the Actuary at

the Health Care Financing Administration (HCFA) estimates that the elderly will spend \$525 per person a year on prescription drugs in 1993. While the source for the projection of \$71 billion to be spent on prescription drugs in 1993 is not mentioned in the press release, it is the same as a HCFA projection that includes spending on over-the-counter drugs and medical sundries, but does not include spending on hospital drugs. HCFA projects that \$44.4 billion will be spent on outpatient prescription drugs in 1993. That amounts to 4.9 percent of National Health Expenditures, projected at \$903.3 billion in 1993 by HCFA. Inpatient drug expenditures are not tabulated by HCFA.

Significantly, the prescription-drug share of overall healthcare expenditures has decreased steadily over the past 30 years and has remained about the same for the last five years.

Mr. Chairman, that concludes my Statement. I would be pleased to respond to any questions that you or other Members of the Subcommittee may have.

Mr. STARK. I find it fascinating that the industry is concerned about underfunding. I must say, your rush to the socially conscious position is heartening, and it is indeed a new posture.

Who is next on our list?

Mr. Haddad.

STATEMENT OF WILLIAM F. HADDAD, CHAIRMAN, GENERIC PHARMACEUTICAL INDUSTRY ASSOCIATION

Mr. HADDAD. Yes. Thank you, Mr. Chairman.

My Name is Bill Haddad. I am a generic pharmaceutical manufacturer and chairman of the Generic Pharmaceutical Industry Association. My involvement with the generic industry dates back to Senator Estes Kefauver, who began the first investigations of the practices of the multinational pharmaceutical companies, their control of the pharmaceutical prices and their techniques and tactics to retard generic competition over 40 years ago.

Mr. Stark, you are the inheritor and protector of a great but very lonely tradition.

I am going to skip the next part of my testimony. But I was the person you quoted about the front organizations. And I will provide for the record that information.

The campaign against the catastrophic health care legislation did not spring full blown from Pantagruel's left ear. It was a stimulated organized campaign.

For 30 years, congressional committees have documented "not only by research and statistics but personal testimony" the plight of the elderly forced to make life and death triage decisions because of the high cost of prescription medicine. The record on that is clear so there is little need to review that history today.

Our industry has consistently supported, both at the Federal and State level, extended coverage to include prescription drugs for the elderly. It would be a tragedy if the Clinton proposal does not include this for the elderly and others as well.

I would like to use one of Mr. Mossinghoff's most accurate and effective arguments, that if you use pharmaceuticals effectively and rationally, you stay out of expensive hospitals. I don't know why that axiom doesn't apply this situation as well. That cost reduction, based on the use of medicine would be hard to codify, but it is there. If the triage patient couldn't obtain their medication, they might not be required to enter a hospital for care.

For cost containment, GPIA has strongly recommended a one-price reimbursement level for multisource drugs, very much like the provision Congress approved for catastrophic. If set at medium AWP, as recommended by Dr. Schondelmeyer of Minnesota, pharmacies will have an ample pool of suppliers who will compete against each other to keep prices down. Market forces will be at work to establish real and not inflated reimbursement prices. The savings from this process alone should pave the way for universal drug coverage.

Let me quote Dee Fensterer, who is president of GPIA, "Our industry can serve as a model of how to use competitive market forces to tame wildfire pharmaceutical costs and thus make possible the inclusion of pharmaceutical benefits in a national policy for universal access to health care."

Let me give a few examples. In 1988, the wholesale price for 100 tablets of Inderal, 80 milligrams, was \$37.97. The generic version costs \$4, but those discrepancies are not unique. These price differences between brand and generics are nearly universal. However, by 1992 the price of the brand had increased 51 percent to \$57.36, while the price of the generic had decreased to \$1.84. That, too, is universal.

Look at Valium, five milligrams, 1988, the wholesale price for 100 tablets, \$26.78; generic version, \$1.84. By 1992, the price of the brand had increased 67 percent to \$44.56, while the price of the generic had decreased 31 percent to \$1.27.

Fifteen years ago, for testimony before Congress, I purchased two little bottles of identical medicine at the same pharmacy; as a consumer I paid \$5 for the identical drug, purchased at the pharmacy, the Federal reimbursement was \$25. And at this time when the Republicans were in charge, and the conservatives shouted louder than Perot for reduced expenditures, and yet they allowed billions of dollars to slip through their budget. I must tell you, Mr. Chairman, that these billions still slip through our hands today. Today, as a customer I can walk into a pharmacy and pay \$5 for a drug for which the Government reimburses, through HCFA, \$25. That is criminal.

Competition works, and it should be nurtured. Let me quote Mr. Zeigler, who is the head of NACDS. He said, "HCFA has managed to create the only prescription drug program in the country that provides an incentive to dispense higher cost, brand name, multiple-source drugs."

Medicaid now reimburses pharmacies \$58.32 for 100 tablets of the Inderal brand of propranolol, but only \$2.33 for generic. Pharmacists received \$84.36 in Medicaid reimbursement for Valium but \$2.10 per hundred of generic. That's criminal.

Any Federal reimbursement program you consider must eliminate this costly discrepancy between brand and generic reimbursement rates. The most effective and efficient solution would be one reimbursement price level, simple, easy to monitor, and sets competitive market forces at work.

I know it is difficult, but to establish effective national policy to keep competition alive, States and the Federal Government must restrain themselves from the political compromises which are disincentives to competition.

Yes, I refer to OBRA 1990 which, by way of political compromises, included generic companies in its rebate program, although the program was clearly designed to force down single source prices. This practice, which is rapidly moving to all third-party programs, has moved some generic companies into the red and may force some to leave the marketplace, while the program has had very little effect on the multinationals in terms of the bottom line.

For example, in Pennsylvania the higher cost of the new drugs that were covered more than made up for the savings of the rebate program. That is called leaving the barn door open. I prefer another cliché. You took an aim at the elk, and you hit the milk cow.

I was asked to comment on the use of formularies. We would suggest you look at the pharmaceutical industry in two ways; one

the innovative brand name company's, and the other, the generic or multisource company's. And the rules for one, as I tried to explain to your friend, Mr. Magaziner, do not apply to the other. And this is particularly true in formularies.

Why do you have a formulary? I am a hospital pharmacist and I want to lower prices of single source drugs, so rub two brand name manufacturers together to get the best price. For similar drugs recommended by my therapeutic committee. In their judgment, one is as good as the other; and the only way you can get price competition is by rubbing them together to force competition. This doesn't apply in the generic industry. We're already a competitive commodity, so while we favor a formulary, it should be an open, multisource formulary, personally I also do not believe any pharmacist program is going to work effectively without some patient incentive not to exploit the program. You need some modest copays. I think that must be included.

I also think Congress should install a monitoring process for the cost and use of prescription drugs.

Finally, I want to take a little bit of advantage of your invitation to expand the testimony with reference to some comments from your colleagues. We settled patent restoration in Waxman-Hatch. We settled it because Congressman Gore was able to expose structured information given to the Congress about patent life. It was not the 7.5 years as claimed; it was more than double that number. So, as part of the compromise, several Congressmen, including Waxman, compiled the real figures; and while they were never made public, I am sure they can be made available to you. Patent life was 15.3 years with 3 additional years attributed to company delay. Why delay?

If you have a great product like Valium, you don't move it as quickly through FDA until the patent expires on your other product in that malpractice, Librium. That, Congress learned, is a fact of business life. So I am rather distressed when I hear the 7.5 year number recycled.

Furthermore, I heard some very good testimony from Ms. Wagner. How do you educate the physicians? Well, Congress had a terrific idea. Some time ago, I returned from the United Kingdom where I reviewed a system that the British used to inform pharmacists about the cost of drugs. It was composed of 5 by 7 cards with price bar graphs on one side and information about the drug on the back. Senator Long wanted HEW to adopt that system because it would bring prices down through information on price discrepancies. And after about a year, HCFA produces a version of the British system and sent it to every physician in America.

HCFA conducted a survey on the impact. Many physicians said, oh, my God, I didn't know how much that drug costs. They said the HCFA chart affected their prescribing behavior.

You know, just like Clinton has been doing with a stroke of a pen, the first thing Reagan did with the stroke of his pen was to eliminate that program. It has not returned under Clinton. It should.

Finally, our industry is going through dramatic changes. Three brand name companies are members of my board of directors. Brand name companies are buying generic companies. Generic

companies manufacture generic drugs for sale by brand name companies. In fact, our industry has been manufacturing for brand name companies for over 20 years. Some of what is happening is terrific, although I tend to paint all brand name companies with one black brush. I think I am going to have to back away from generalizations because there are breaks in the wall. Some brand name companies are changing their policies, and my criticisms don't apply.

There are new programs out, new strategies. And I think there is an area now for cooperation as well as confrontation. And I would suggest that might be the way through some of this national health insurance minefields.

Thank you very much for your time.

Mr. STARK. Thank you for your testimony.

[The prepared statement and attachments follow:]

**TESTIMONY OF WILLIAM F. HADAD
GENERIC PHARMACEUTICAL INDUSTRY ASSOCIATION**

My name is William F. Haddad. I am Chairman of the Generic Pharmaceutical Industry Association. I was most recently Vice Chairman of Schein Pharmaceutical which manufactures five hundred generic drugs. I am now the Chairman and CEO of a company that is focusing on creating a generic pharmaceutical industry in third world countries where outrageous prices are paid for prescription pharmaceuticals. I am also Chairman and CEO of an international company, MIR Pharmaceutical, which is working to create a generic pharmaceutical industry in the former Soviet Union. MIR's shareholders include the major generic companies worldwide.

My involvement with the generic pharmaceutical industry dates back to the late Senator Estes Kefauver who began the first investigations of the practices of the multinational pharmaceutical companies and their control of pharmaceutical prices and their techniques and tactics to retard generic competition. My stories for the New York Herald Tribune exposed the tetracycline cartel and led to \$200,000,000 in fines...but no one went to jail. As head of an investigation commission in New York, our exposes of the industry led to the repeal of the anti-substitution law that prohibited competition from generic drugs. It was during those hearings that we learned that 160 off patent pharmaceuticals had no competition due to informal and improper political restraints by both Congress and the Administration. I was the generic industry's negotiator for the Drug Price Competition and Patent Term Restoration Act of 1985 and the process patent legislation. I was appointed to the Congressionally mandated committee to oversee the Catastrophic Health Insurance legislation.

I learned three things from that thirty year war. First, the industry moves in mysterious ways often using front organizations to carry their message; these range from universities, to medical associations, to medical publications and even to covertly financed organizations created to represent the elderly, but which are controlled by brand name companies and only serve to make their viewpoints seem acceptable to senior citizens and give some Members of this distinguished body and officials in past Administrations a chance to argue that the senior citizens are divided on the pharmaceutical issue. That's how we lost the Medicare Catastrophic battle. I am relatively certain that similar tactics will be used to frustrate your efforts.

Second, the brand name multinationals work effectively as long as they can influence behind closed doors; when the discussion finds the light of day, their covert power dissipates; that's what happened during the Drug Price Competition legislative process.

Finally, our industry, time and again, has been saved by a few courageous legislators: Kefauver, Senator and Congressman Long, Senator Nelson, Congressmen Gore and Waxman, Senator Kennedy, Senator Hatch...yes, Senator Hatch...and in this go-around Senator Pryor and yourself. I never thought I would live to see the day when a President of the United States...and his articulate wife...would take up this cause. Congressman Stark, you are the inheritor and protector of a great but lonely tradition.

Mr.Chairman, for thirty years Congressional Committees, including your own, have documented, not only by research and statistics, but by personal testimony, the plight of the elderly without prescription drug coverage. Many of the elderly must make triage choices each month: do I pay for my medicine, or do I pay for food or rent? Many make the wrong choice, as Senator Pryor's Committee discovered a few years ago. One woman, requiring a constant level of medication, had decided to use her drug every other day, creating a situation which endangered her life. It is not an exaggeration to conclude that people die for want of a pharmaceutical that costs a penny or two to manufacture.

Our industry has consistently supported, both at the federal and state level, extended coverage to include prescription drugs for the elderly. It would be a tragedy if the Clinton proposal does not include that coverage.

May I take a moment to talk about the Clinton process. Under previous administrations, Democrat and Republican, pharmaceutical decisions were made behind closed doors without the generic industry having access to the process. Often, the results of these discussions were written into legislation or administrative practices or guidelines by the multinational companies themselves and merely promulgated by the political leaders. By contrast, from the very beginning of the current Administration, the generic industry was afforded equal footing with the multinational brand companies. We were invited in, questioned, asked our views and then invited back several times at various levels of the process. I could not care less about the names of those recruited to conduct the process. What counted was that we were included...and for the first time we had access to the process. We were most impressed by the people we met...including the young men and women...they knew our business as well as we did and they did not waste time on the cliché arguments about the cost of research or the effectiveness of generic drugs, but they engaged us in sophisticated discussions, including our views on how prescription drug coverage could be extended to all Americans. Mrs. Clinton and Mr. Magaziner have put together one hell of a team. We can not imagine suggested legislation which does not include mandatory generics and universal prescription drug coverage.

GPIA has strongly recommended a one price reimbursement level for multisource drugs. If set at medium AWP, as recommended by Dr. Stephen Schondelmeyer of Minnesota, pharmacists will have an ample pool of suppliers who will compete against each other to keep prices down. Market forces will be at work to establish real not inflated reimbursement prices. The savings from this process alone should pave the way for universal drug coverage.

Let me quote Ms. Dee Fensterer, who is the President of GPIA, when she testified before the Health Care Task Force in March of this year:

"Our industry can serve as a model of how to use competitive market forces to tame wildfire pharmaceutical costs, and thus make possible the inclusion of pharmaceutical benefits in a national policy for universal access to healthcare."

Let me cite some examples of savings from a mandatory generic policy. In 1988, the wholesale price for 100 tablets of Inderal (80mg) was \$37.97. The generic version cost \$4.00. But that's not the story. Those price differences are nearly universal.

By 1992, the price of the brand had increased fiftyone percent to \$57.36, while the price for the generic had decreased to \$1.84. That, too, is universal.

Let's look at Valium (5mg). In 1988 the wholesale price for 100 tablets was \$26.78, while the generic version cost only \$1.84. But by 1992, the price of the brand had increased sixtyseven percent to \$44.56, while the price of the generic had decreased thirtyone percent to \$1.27.

There is price competition among generic manufacturers. The market system works. It should be nurtured, encouraged, rewarded.

When there is competition, the market system works.

While, on one hand the U.S. government advocates market economics in most of the countries in which I work, they don't follow that policy in their own reimbursement programs. Ron Zeigler, President of the National Association of Chain Drug Stores told Congress in 1990:

"HCFA has managed to create the only prescription drug coverage program in the country that provides an incentive to dispense higher cost, brand named multiple-source drugs."

Medicaid now reimburses pharmacies \$58.32 for 100 tablets of the Inderal brand of propranolol (80mg) but only \$2.33 for the generic version. Pharmacists receive \$84.36 in Medicaid reimbursement for Valium-brand diazepam (10mg), but only \$2.10 for 100 tablets of the generic equivalent. (I have attached to my

testimony similar statistics for other Medicaid reimbursements).

With reimbursement differentials such as these, pharmacists have little or no incentive to dispense generics. As Ms. Fensterer pointed out in her Congressional testimony, one pharmacist candidly said that "when he receives a Medicaid prescription that requires generic substitution, he would make more profit by putting a messenger in a taxi, sending him back to the doctor and securing an approval to dispense the brand name product.

Any federal reimbursement program you consider must eliminate this costly discrepancy between brand and generic reimbursement rates. The most effective and efficient solution would be one reimbursement price level for each multisource drug.

I know it is difficult, but to establish effective national policy to keep competition alive, states and the federal government must restrain themselves from the political compromises which are disincentives to competition. Yes, I refer to OBRA 90 which, by way of political compromise, included generic companies in the rebate program, although the program was clearly designed to force down single source prices. This practice, which is rapidly moving to cover all third party programs, has moved some generic companies into the red and may force some to leave the marketplace while the program has had very little impact on the multinationals, who, after all, were the target because of their structured pricing. And even on overall reduction of the cost of prescribing to government this program has had little impact if we are to judge from the early reports. For example, in Pennsylvania, the higher cost of the new drugs that were covered more than made up for the savings of the rebate program. That's called "leaving the barn door open." To use another cliché, they took aim at the elk and hit the milk producing cow.

I was asked to comment on the use of formularies. We would suggest that you look at the pharmaceutical industry as two distinct industries, the brand or multinational and the generic or multisource industry.

Why are formularies created by hospitals and others? To save money by rubbing one brand name company against another when the companies manufacture products which can be therapeutically interchanged, at least in the judgement of the formulary committees. The company that reduces its price, gets the business. That's a logical process for single source products.

Generics, however, compete effectively on all products and when the bid comes in from a hospital, companies respond with competing prices. The hospital selects the lowest prices for a medically identical product. Medical interchangeability is a result of the FDA approval process. This, too, is a logical practice for multisource drugs. Competition works and in our industry it needs

no encouragement.

GPIA strongly favors some national standards, including a national open multisource drug formulary, to pre-empt individual state initiatives that disrupt effective marketplace forces and thereby reduce, rather than enhance, pharmaceutical price competition.

From my personal experience, I would urge a modest co-pay for prescription drugs. This, I believe, can help to produce the rational use of prescription drugs. I would also protect the right of the consumer to purchase a brand name multisource product, provided the cost is not subsidized by the government.

I urge the Congress to install a monitoring process for the cost and use of prescription drugs. The Catastrophic legislation provided for such a program and I personally believe the inclusion of these monitoring devices helped to spur the attack by the multinationals on the program. Facts about cost and utilization often can not stand the light of day.

Thank you for hearing me out.

Generic Pharmaceutical Industry Association

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W H A T M E D I C A I D P A Y S F O R E Q U I V A L E N T B R A N D A N D G E N E R I C D R U G S

<u>Drug</u>	<u>Brand Reimbursement</u>	<u>Generic Reimbursement</u>
Clinoril 200 mg tabs	99.18	45.47
Minipress 5 mg caps	90.00 (100's in UD)	13.73
Vibramycin 100 mg caps	147.50	11.25
Tranxene 7.5 mg tabs	112.54	4.88
Soma 350 mg tabs	134.30	5.93
Valium 10 mg tabs	84.36	2.10
Keflex 250 mg caps	110.17	14.93
Inderal 80 mg tabs	58.32	2.33

Package size: 100's (except Vibramycin 50's)

Sources: Generics - HCFA Upper Limit Reimbursement Prices:
HCFA State Medicaid Manual - Payment for services
Oct. 1992.

Brands - HCFA Reimbursement Prices based on AWP minus
10% MediSpan, Second Quarter 1993.

**A COMPARISON OF GROWTH
IN WHOLESALE ACQUISITION PRICE
FOR TWELVE BRANDED PHARMACEUTICALS
AND THEIR GENERIC COMPETITORS**

March, 1993

**Prepared by:
The Pharmaceutical Marketing and Management Program
Health Services Research Division
Research Institute of Pharmaceutical Sciences
School of Pharmacy
The University of Mississippi**

SUMMARY

The pricing behavior of generic pharmaceuticals differs substantially from that of branded drugs. While the prices of branded drugs tend to increase each year, it is much more common for the price of a generic pharmaceutical product to decline from year to year. While some generic products can, occasionally, enjoy positive price growth, continual decreases in selling prices is the norm for these products.

BACKGROUND AND METHODOLOGY

This report was prepared to demonstrate the fundamental difference in pricing behavior between brand-name pharmaceutical products and their generic competitors. In order to illustrate this difference, twelve commonly-prescribed branded pharmaceutical products with generic competition were chosen. This analysis is based on a review of the wholesaler acquisition price histories of those products. The prices were supplied by a major drug wholesaler doing business in the eastern United States, and are similar to those available to all drug wholesalers at the time. Prices used in the analysis were those available in June of each year studied, 1988 through 1992.

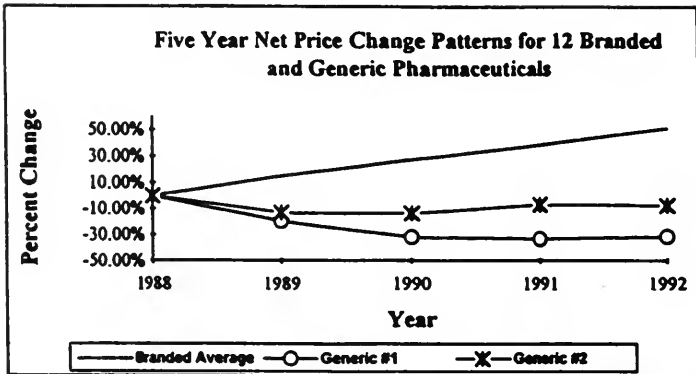
Since no sales figures for the individual products are used in this report, aggregate figures in this analysis are provided for illustrative purposes only and are not meant to be interpreted as reflecting weighted average changes. They do, however, provide assistance in pointing out the real differences in pricing behavior between branded and generic pharmaceuticals.

ANALYSIS

While the competition between the various brand-name pharmaceutical products is based primarily on product differentiation, generic pharmaceuticals compete against the brand mainly on the basis of price. This basic difference is understood by most observers of pharmaceutical markets. A major difference between brands and generics that tends to be less well-known, however, is the fierce price competition that exists between the several generic versions of the same pharmaceutical compound. For generic pharmaceuticals, intense price competition between the individual firms is, perhaps, the most significant feature differentiating them from their branded counterparts.

Due to the intensity of this price competition, generic pharmaceutical manufacturers have not enjoyed the same pricing freedom that the manufacturers of branded pharmaceuticals have. In fact, while the past decade has seen the prices of most branded drugs increase, the typical pricing pattern for generic pharmaceuticals is the continued decrease in prices over time, as competition between generic manufacturers exerts constant downward pressure on prices.

This basic difference between branded and generic pharmaceuticals is illustrated in the following graph, in which the average annual price growth for branded and generic products is shown. Please note that this information is based upon the simple mean average price change for the 12 branded and generic products chosen for this analysis. The numbers should not be construed as industry averages.



As this graph illustrates, the price trend for branded pharmaceuticals has traditionally been ever-upward, while the prices of generic products, by-and-large, trend downward over time.

The graphs that make up the remainder of this report, and the data presented therein, were compiled to demonstrate the basic difference between branded and generic pharmaceuticals. The products within this report were selected based upon the immediate availability of data. While more than two generics have been generally available for each of these products, those selected for this analysis were stocked for each of the five years under investigation by the wholesaler whose prices are the basis of this analysis. The products of several different branded and generic companies were used in this report. The selected products are listed on the following page.

The price competition which is a major aspect of the generic pharmaceutical industry is not present in the same intensity among branded pharmaceuticals. As such, the marketplace holds generic prices in check, and the need for intervention to hold or further reduce the prices of generic products cannot be deemed necessary or appropriate.

Please address any questions concerning this report to:

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Generic Pharmaceutical Pricing Trends

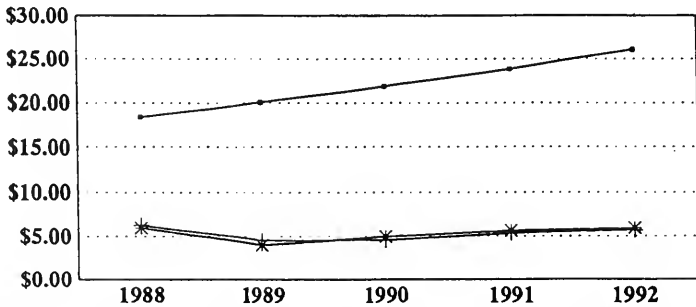
BRANDED AND GENERIC PHARMACEUTICAL PRODUCTS USED FOR THIS ANALYSIS

BRAND	COMPOUND
Darvon (Eli Lilly)	propoxyphene Compound 65MG
Elavil (Merck. Stuart)	amitriptylene 25mg
Motrin (Upjohn)	ibuprofen 400mg
Inderal (Wyeth-Ayerest)	propranolol 80mg
Diabinese (Pfizer)	chlorpropamide 100mg
Tolinase (Upjohn)	tolazemide 100mg
Valium (Roche)	diazepam 5mg
Restoril (Sandoz)	temazepam 15mg
Dalmane (Roche)	flurazepam 15mg
Tylenol #3 (McNeil)	APAP w/ codeine #3
Bactrim (Roche)	sulfamethoxazole/trimethoprim 80/400
Lasix (Hoechst)	furosemide 20mg

Price Trend Differences, 100 Doses

Darvon Vs Propoxyphene CMPD 65mg

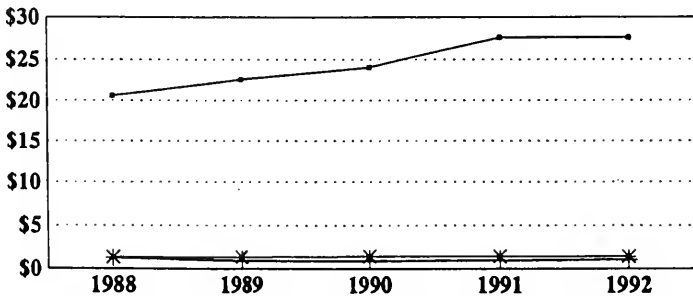
Wholesaler Acquisition Price, June of Each Year



→ Darvon + Generic 1 * Generic 2

Elavil Vs Amitriptylene 25mg

Wholesaler Acquisition Price, June of Each Year

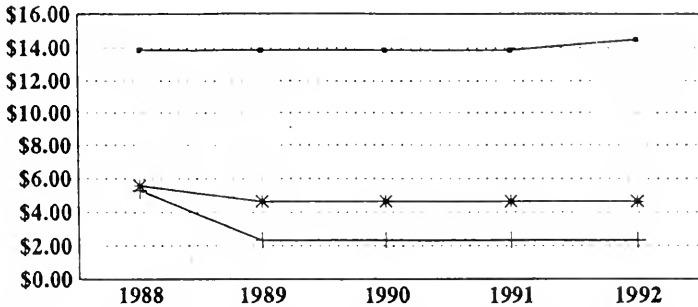


→ Elavil + Generic 1 * Generic 2

Price Trend Differences, 100 Doses

Motrin Vs Ibuprofen 400mg

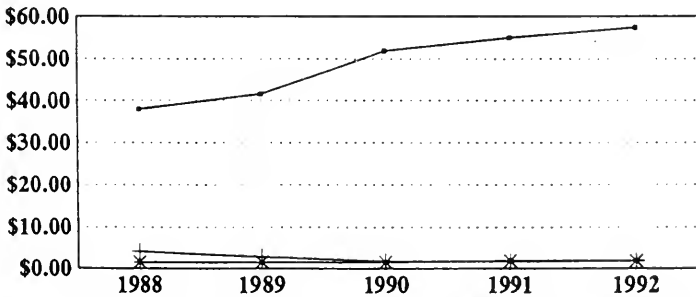
Wholesaler Acquisition Price, June of Each Year



→ Motrin + Generic 1 * Generic 2

Inderal Vs Propranolol 80mg

Wholesaler Acquisition Price, June of Each Year

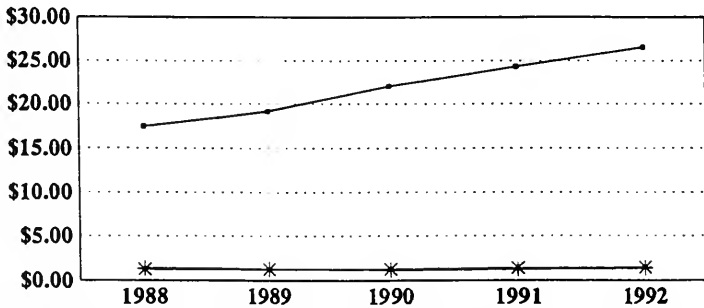


→ Inderal + Generic 1 * Generic 2

Price Trend Differences, 100 Doses

Diabinese Vs Chlorpropamide 100mg

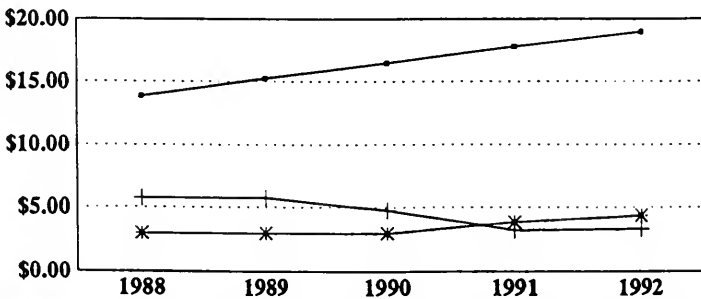
Wholesaler Acquisition Price, June of Each Year



→ Diabinese + Generic 1 * Generic 2

Tolinase Vs Tolazamide 100mg

Wholesaler Acquisition Price, June of Each Year

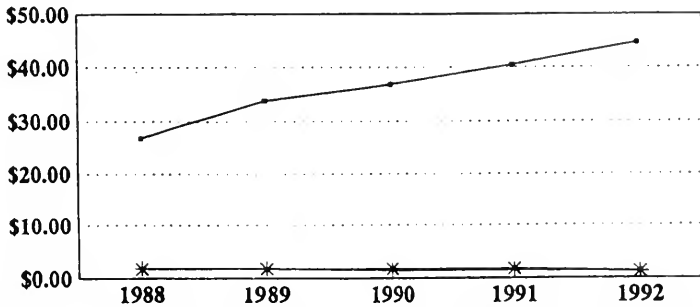


→ Tolinase + Generic 1 * Generic 2

Price Trend Differences, 100 Doses

Valium Vs Diazepam 5mg

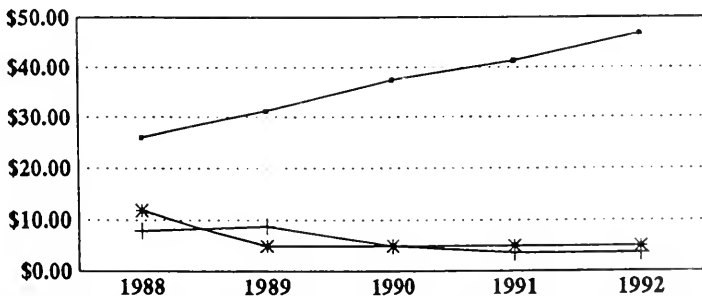
Wholesaler Acquisition Price, June of Each Year



→ Valium + Generic 1 * Generic 2

Restoril Vs Temazepam 15mg

Wholesaler Acquisition Price, June of Each Year

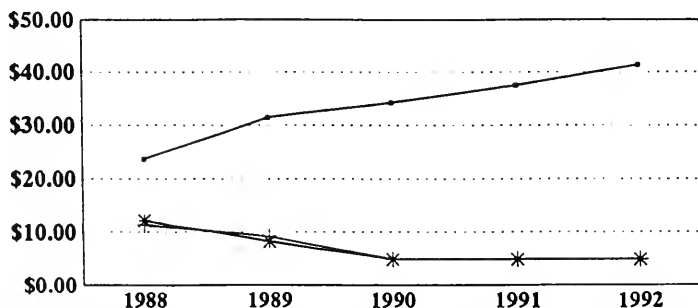


→ Restoril + Generic 1 * Generic 2

Price Trend Differences, 100 Doses

Dalmane Vs Flurazepam 15mg

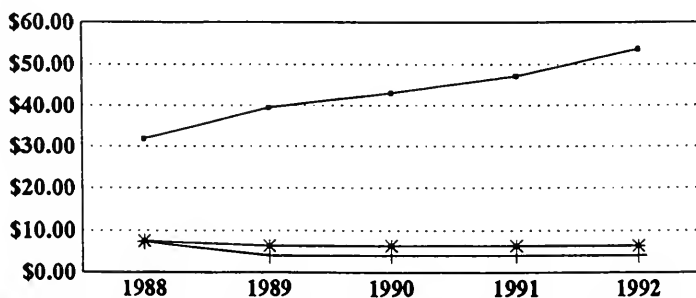
Wholesaler Acquisition Price, June of Each Year



→ Dalmane + Generic 1 * Generic 2

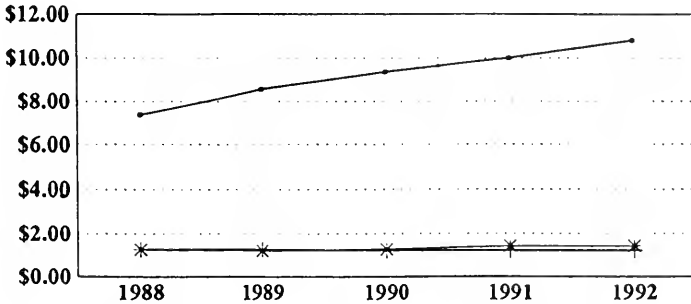
Bactrim Vs Trimethoprim/Sulphmethoxazole

Wholesaler Acquisition Price, June of Each Year



→ Bactrim + Generic 1 * Generic 2

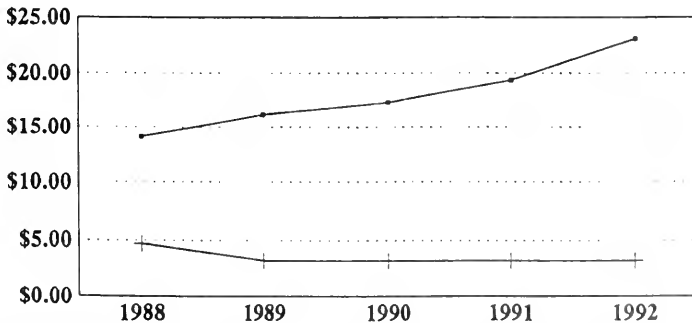
Price Trend Differences, 100 Doses Lasix Vs Furosemide 20mg Wholesaler Acquisition Price, June of Each Year



Lasix	\$7.38	\$8.58	\$9.38	\$10.00	\$10.80
Generic 1	\$1.27	\$1.27	\$1.22	\$1.22	\$1.22
Generic 2	\$1.27	\$1.21	\$1.27	\$1.42	\$1.42

→ Lasix + Generic 1 * Generic 2

Tylenol#3 Vs APAP w/Codeine #3 Wholesaler Acquisition Price, June of Each Year



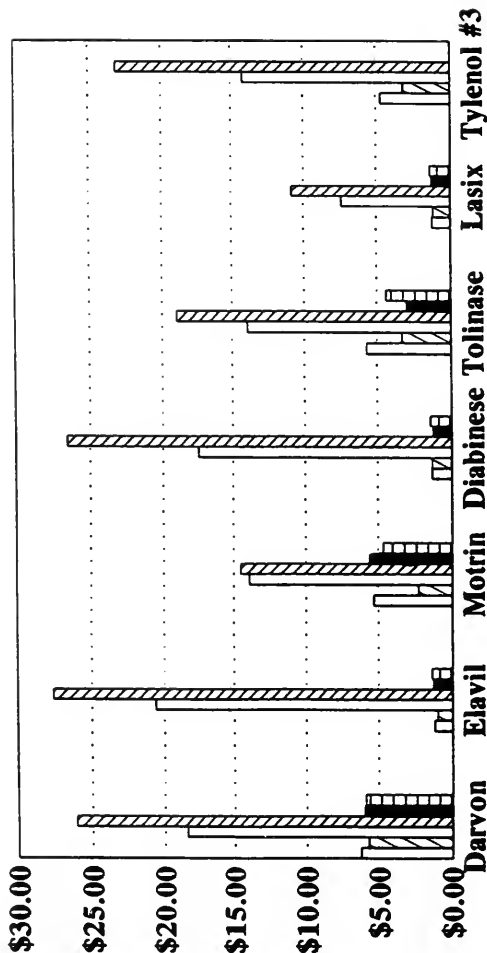
Tylenol #3	\$14.12	\$16.17	\$17.30	\$19.38	\$23.10
Generic 1	\$4.70	\$3.21	\$3.21	\$3.21	\$3.21

→ Tylenol #3 + Generic 1

Price Growth Comparisons

Brands and Generics 1988 to 1992

Wholesaler Acquisition Price, June of Each Year

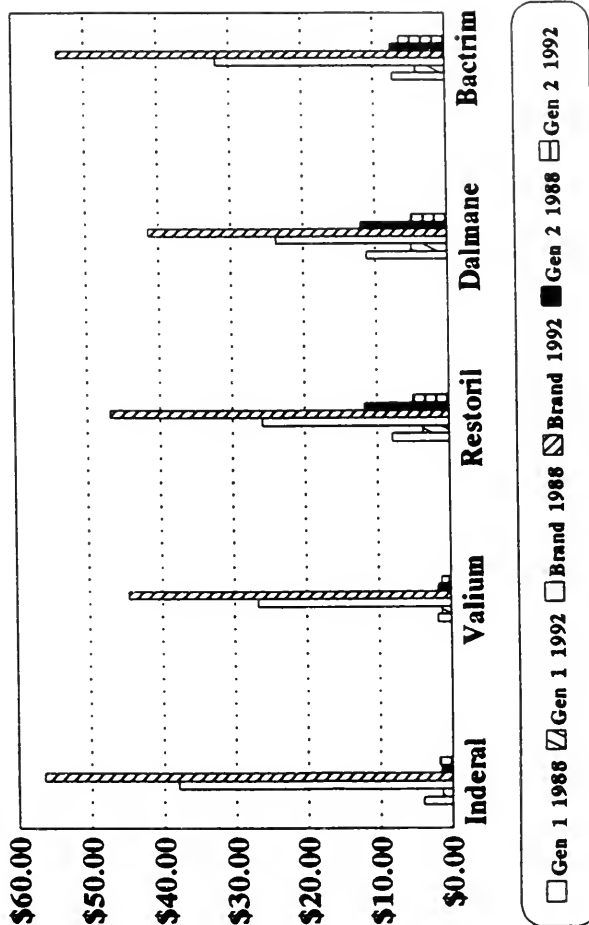


The University of Mississippi

Price Growth Comparisons

Brands and Generics 1988 to 1992

Wholesaler Acquisition Price, June of Each Year



The University of Mississippi

Mr. STARK. Mr. Webster.

STATEMENT OF R. TIMOTHY WEBSTER, EXECUTIVE DIRECTOR, AMERICAN SOCIETY OF CONSULTANT PHARMACISTS, ON BEHALF OF THE COALITION FOR CONSUMER ACCESS TO PHARMACEUTICAL CARE, ACCOMPANIED BY LINDA GOLODNER, PRESIDENT, NATIONAL CONSUMERS LEAGUE

Mr. WEBSTER. Thank you, Mr. Chairman, members of the subcommittee. I am accompanied today by Linda Golodner, president of the National Consumers League. We are testifying today on behalf of the Coalition for Consumer Access to Pharmaceutical Care. This is a national coalition of pharmacists and consumer organizations whose purpose is to increase awareness and utilization of the benefits of pharmaceutical care.

The organizations in the coalition are identified in our written statement. The coalition supports efforts to reform the existing health care system, including improvements to the Medicare program that will insure access to quality health care for all Americans. We believe it is critical that professional pharmacy services, pharmaceutical care, be recognized as part of the solution to the three most significant problems in health care reform: escalating costs, insufficient access, and inconsistent quality.

More than anything else, the coalition believes in the beneficial effect of drug therapies and the need to maximize this benefit on behalf of consumers. Pharmacist services can assure that the most cost-effective medication is being given to the patient and that the patient knows how to take the medication properly.

Our most compelling message is that pharmacists make a substantial difference in the effectiveness of drug therapy. They are available in every community and health care setting and can save the health care system far more money than their services cost. Simply put, no prescription drug benefit can be effective, either from a therapeutic or cost perspective, without incorporating pharmacist services.

Pharmaceutical care is the process by which a pharmacist interacts directly with a patient and other health care professionals to design, implement, and monitor a therapeutic plan that improves the patient's quality of life. Specific pharmaceutical care services provided by pharmacists will include: monitoring drug compliance, reviewing of medication used to assure quality outcomes, counseling the patients to assure adequate understanding of the prescribed medications, identifying and resolving drug interactions, selecting cost-effective generic drug products, and providing case management within or outside a managed health care plan, to coordinate medication use as an individual goes from the community to a hospital or long-term care setting.

As Ms. Golodner's presence indicates, consumers believe pharmacists can make a significant contribution to their health care. For example, in our written testimony, we have provided the results of a recent AARP survey that documents the high degree to which older Americans benefit from the services of pharmacists. Nevertheless, critical problems remain. Of the surveyed population, 42 percent do not always comply with their doctor's orders. And 29 percent stop taking the medication before it runs out.

Because of these and other problems, the combining of medications with pharmaceutical care offers an accessible and effective method for treating disease. Each year a significant amount of money is spent on unnecessary medications and to treat illnesses that result from inappropriately managed therapy.

Consider the following: Medication-related problems, such as noncompliance by patients, is responsible for an estimated 10 percent of all hospital admissions and 23 percent of all nursing home admissions. The failure to fill or refill prescriptions has resulted in an estimated cost of \$8.5 billion for increased hospital admissions and physician visits, nearly 1 percent of the country's total health care expenditures.

Drug interactions and adverse drug reactions are said to account for about 70 percent of all hospitalizations. Yet about 70 percent of adverse effects are predictable and preventable through logical application of existing information.

A recent study of medication errors in pharmacist interventions conducted in community pharmacies found that over one-fourth of medication errors identified and corrected by pharmacists could have resulted in harm to the patient. The direct cost of medical care that was avoided as a result of pharmacist interventions was estimated to be at least \$123 per problematic prescription.

Mr. Chairman, in conclusion, pharmacists are readily available in every community, hospital, long term care facility, managed care network, and HMO. They are ready to make this contribution to better, more cost-effective health care. When pharmacists, the health care professionals most knowledgeable about the use of pharmaceutical products, undertake these care giving activities, they save the system billions of dollars and improve the health of millions.

This subcommittee has the opportunity to create a sound, cost-effective pharmaceutical care situation for our Nation. We urge you and your colleagues to take this opportunity by incorporating pharmaceutical care services into a prescription drug benefit in Medicare. The pharmacy profession is committed to helping you meet the challenge of providing accessible quality and cost-effective health care to beneficiaries of the Medicare program.

This concludes our oral remarks and the summary of our written statement for the record.

Ms. Golodner and I would be pleased to answer the subcommittee's questions and to work with you to make sure that are our Nation's elderly receive the care that they deserve.

Mr. STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF R. TIMOTHY WEBSTER COALITION FOR CONSUMER ACCESS TO PHARMACEUTICAL CARE

Mr. Chairman, my name is Tim Webster. I am a pharmacist and the Executive Director of the American Society of Consultant Pharmacists. I am accompanied by Linda Golodner, President of the National Consumers League. We thank you for the opportunity to testify and applaud your leadership in advocating "a reasonable drug benefit for seniors paired with an effective cost containment strategy for pharmaceutical products."

We are testifying today on behalf of the Coalition for Consumer Access to Pharmaceutical Care. This is a national coalition of pharmacist and consumer organizations whose purpose is to increase awareness and utilization of the benefits of pharmaceutical care.

In addition to our two organizations, the membership of the Coalition consists of the Academy of Managed Care Pharmacy, the American Association of Colleges of Pharmacy, the American College of Clinical Pharmacy, the American Pharmaceutical Association, the American Society of Hospital Pharmacists, and the National Pharmaceutical Association.

The Coalition supports efforts to reform the existing health care system, including improvements to the Medicare program, that will assure access to quality health care for all Americans. Within this effort, we believe it is critical for professional pharmacy services--pharmaceutical care--to be recognized as part of the solution to the three most significant problems in health care reform: escalating costs, insufficient access, and inconsistent quality.

More than anything else, we believe in the beneficial effect of drug therapies and the need to maximize this benefit on behalf of consumers. One critical key is the utilization of pharmacist services to assure that the most cost-effective medication is being given to the patient and that the patient knows how to properly take the medication.

Our most compelling message is that pharmacists make a substantial difference in the effectiveness of drug therapy. They are available in every community and health care setting, and can save the health care system far more money than their services cost. Simply put, no drug product benefit can be effective, either from a therapeutic or cost perspective, without incorporating pharmacist services.

PRINCIPLES OF PHARMACEUTICAL CARE

Pharmaceutical care is the process in which a pharmacist is involved in direct interaction with a patient and other health care professionals in designing, implementing, and monitoring a therapeutic plan that will produce clinical outcomes that improve

the patient's quality of life. Specifically, the pharmaceutical care services provided by pharmacists include: monitoring drug compliance; systematic review of medication use to assure quality outcomes; patient counseling to assure adequate understanding of the prescribed medications; identifying and resolving drug interactions; selecting cost-effective generic drug products; and case management (within or outside a managed care health plan) which coordinates medication use as an individual goes from the community to a hospital or long-term care setting.

Our Coalition, and nearly 50 other state and national pharmacy organizations, are united in endorsing four principles fundamental to the organization and delivery of pharmaceutical care under a revised Medicare program or under a reformed health care system. These are:

- Pharmaceutical products and pharmaceutical care (pharmacists' services) should be included as a core benefit in a reformed health care system.
- Pharmacists' services and proper management of medications can generate significant savings to a reformed health care system.
- Quality assurance programs administered by pharmacists can significantly improve the effectiveness of medications in achieving positive patient outcomes.
- Integrated information systems that include pharmacists offer the potential for cost savings and better patient outcomes.

These principles are described further in four one-page position statements that are appended to our testimony.

PROBLEMS ADDRESSED BY PHARMACEUTICAL CARE

Both the need for good pharmaceutical care and the problems it addresses were graphically illustrated by a 1991 AARP survey of individuals 45 and older. It documents the degree to which older Americans benefit from the services of pharmacists--

- 33% cite pharmacists as their principal source of information about prescription drugs;
- 63% are likely to ask their pharmacist questions when having a prescription filled for the first time;
- 83% will ask their pharmacist questions about a new prescription drug if the questions arise after they leave the doctor's office; and

- 92% are satisfied by the quality of the information provided by their pharmacist.

Yet even with this level of attention, critical problems remain. Of the survey population--

- 42% do not always comply with their doctor's orders;
- 29% sometimes stop taking the medication before it runs out;
- 22% sometimes take less of a drug than the amount prescribed on the label;
- 14% sometimes decide not to fill their prescription at all;
- 13% sometimes fill their prescription but do not take any of their medication.

Because of these problems, the combining of medications with pharmaceutical care offers an accessible and effective method for treating disease. Each year a significant amount of money is spent for unnecessary medications and for the cost of treating illnesses that result from inappropriately managed therapy. Consider the following:

- Medication-related problems, such as noncompliance by patients, is responsible for an estimated 10% of all hospital admissions and 23% of all nursing home admissions.
- The failure to fill or refill prescriptions has resulted in an estimated cost of \$8.5 billion for increased hospital admissions and physician visits---nearly one percent of the country's total health care expenditures.
- Drug interactions and adverse drug reactions are said to account for about 7% of all hospitalizations; yet about 70% of adverse effects are predictable and preventable through logical application of existing information.
- A recent study of medication errors and pharmacist intervention conducted in community pharmacies found that over one-fourth of medication errors identified and corrected by pharmacists could have resulted in harm to the patient. The direct cost of medical care that was avoided as a result of pharmacists' interventions was estimated to be \$123 per problematic prescription.

HISTORY OF CONGRESSIONAL SUPPORT FOR PHARMACEUTICAL CARE

Congress, through several enactments, has already acknowledged the value of pharmaceutical care.

In large part because of your efforts Mr. Chairman, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), relevant portions of which became effective on January 1, 1993, mandates pharmacists' counseling services and prospective drug utilization review for patients covered under the Medicaid program. This was a recognition (as were the more limited pharmacists' services provisions in the earlier Medicare catastrophic legislation) that pharmacists' services improve the quality of care provided to beneficiaries of public programs and that access to effective medications is reduced if these populations are not provided good information and supportive services. While OBRA 90 has been an important landmark, it has occurred against a backdrop in which many pharmacists have adopted counseling and drug use review as their standard of practice for all their patients even prior to implementation of OBRA 90.

The process of formalizing pharmaceutical care services and developing innovative payment mechanisms is already well-advanced, as reflected in the attached article by Dale Christensen, entitled "A Practical Billing and Payment Plan for Cognitive Services" from American Pharmacy. In addition, OBRA 90 mandates demonstrations of pharmacist services and payment methodologies.

CONSUMER SUPPORT FOR PHARMACEUTICAL CARE

From the standpoint of the consumer, pharmaceutical care is a winner because the proper use of safe and effective drugs can be among the most cost-effective forms of medical care. Every American should have access to needed medications and the supporting services of a pharmacist to achieve the full benefits. As described above, the real life usage of drug products often falls far short of this ideal.

It is for this reason that the National Consumers League (NCL) chose to join the Coalition for Consumer Access to Pharmaceutical Care. NCL understands how important pharmacist services are to effective drug therapy and how pharmaceutical care makes a difference from the viewpoint of patients and consumers.

It is NCL's consumer members who our pharmacist members serve every day. In fact, the equivalent of the entire American population enters a pharmacy weekly.

From our joint experience as pharmacists and consumers, we know that access and quality of care are directly linked to cost: the

rising burden of prescription medications has meant that many Americans, especially older Americans, are unable to afford all of the prescriptions they require, resulting in sub-optimal care. While pharmacists cannot resolve this problem directly, they can make sure that lower cost medications are used, when appropriate, and that patients understand when and how to use medications so that other costs are avoided.

Not only are pharmacists the most knowledgeable health care professional on the use of pharmaceutical products, but they are the most accessible health professional. In addition to the pharmaceutical care services we have described, pharmacists are an important source of health education information and are readily available in communities and health care institutions, 24 hours a day.

That access is especially critical to older and less wealthy communities where poor health is common, health professionals often remote and less accessible, and health knowledge may be quite low.

In addition, requiring a pharmaceutical care benefit with a Medicare drug product benefit will allow differences in needs to be recognized. A recent study has found that there are important differences in response to medications among different ethnic and racial minority groups. To respond to this, access to pharmaceuticals and pharmaceutical care must be broad and flexible enough to allow medication prescribing, dispensing choices, counseling, and monitoring to be as individualized as necessary.

As the Chairman has noted, cost has become a significant limiting factor for many senior citizens in their access to the benefits of medications. A Medicare drug benefit will help, but one that does not adequately control costs will soon become unaffordable both for individuals and our nation. Much of the elderly population are less able to afford to subsidize their health care needs from disposable income. Pharmaceutical care can play a significant role in maintaining affordability and decreasing the costs associated with non-compliance and adverse effects of prescribed drug regimens.

CONCLUSIONS

The profession of pharmacy has expanded over the last several decades, from a profession focusing primarily on the preparation and dispensing of medications to one in which pharmacists provide more patient-oriented pharmaceutical care services to help ensure the maximum effectiveness of medications. Without question, consumers benefit when pharmacists serve!

Pharmacists are readily available in every community, hospital, long-term care facility, managed care network, and HMO--ready to make this contribution to better, more cost-effective health care.

When pharmacists, the health care professional most knowledgeable about the use of pharmaceutical products, undertake these care giving activities, they save the system billions of dollars and improve the health of millions.

Through your efforts to improve the Medicare program and reform the overall health care system, this Subcommittee has the opportunity to create a sound, cost-effective pharmaceutical care system for our nation. The Coalition for Consumer Access to Pharmaceutical Care urges you and your colleagues to seize the moment by implementing the four principles found within our testimony. Be assured of the pharmacy profession's commitment to help you meet the challenge of providing accessible, quality and cost effective health care to beneficiaries of the Medicare program.

Mr. Chairman, this concludes my remarks. Ms. Golodner and I would be pleased to answer the subcommittee's questions about pharmaceutical care and consumer support for it.



Coalition for Consumer Access to Pharmaceutical Care

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Pharmacy (AMCP)

American Pharmaceutical
Association (APHA)

American Society of
Consultant Pharmacists (ASCP)

American Society of
Hospital Pharmacists (ASHP)

National Consumers
League (NCL)

National Pharmaceutical
Association (NPA)

Pharmaceuticals and Pharmaceutical Care as a Core Benefit

Position:

Pharmaceutical products and pharmaceutical care (pharmacists' services) should be included as a core benefit in a reformed health care system.

Rationale and Impact:

Access to pharmaceuticals and pharmaceutical care is a necessary component of any health care reform proposal that strives to control costs and provide quality care. Appropriately managed pharmaceutical therapy improves patients' quality of life and lowers overall health care expenditures by reducing the need for more costly services (e.g., hospitalizations, long-term care, surgery).

Discussion:

Medications are used to successfully diagnose, prevent and treat major acute and chronic illnesses and slow or halt the progression of more serious conditions. Although prescription medications represent only 7 to 10 percent of the total health care dollar, when utilized properly their financial impact is far more significant.

Patients often fail to gain optimal effectiveness from pharmaceuticals under the current system because of a lack of access and, in some cases, poorly coordinated care. Also, a higher portion of prescription costs are borne out-of-pocket by consumers in comparison with other health care services. This results in access problems for those without adequate insurance coverage. In addition, the U.S. spends enormous sums of money on medicines that are used inappropriately or to treat illnesses that result from the inappropriate use of medicines, including unneeded drugs prescribed for an illness, the wrong use of correct drugs, wrong doses and dosing schedules, lack of compliance with appropriate therapy, and blind compliance with inappropriate therapy.

A pharmaceutical benefit in a reformed health care system should acknowledge that patients have differentiated needs for pharmaceutical products and services. Pharmacists, in collaboration with physicians, patients and other providers of health care services, can work to manage and improve the drug-use process and maximize therapeutic outcomes in patients according to their individual needs for care. An effective pharmaceutical care program with appropriate competitive incentives for providers is a reasonable and cost-effective component of a reformed health care delivery system.

MARCH 1993



Coalition for Consumer Access to Pharmaceutical Care

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Association (NPA)

Managing the Economics of Pharmaceuticals and Pharmaceutical Care

Position:

Pharmacists' services and the proper management of medications can generate significant savings to a reformed health care system.

Rationale and Impact:

Medications and pharmaceutical care offer an accessible and cost-effective method for treating disease, but only when properly used. The current system lacks incentives and presents obstacles to optimal patient outcomes. The goals of economic reform for pharmaceutical products and pharmacists' services are to: 1) maximize the return on the investment made in expenditures for medications, 2) increase market-based competition in the industry while eliminating cost-shifting between market segments, and 3) alter the incentives for patients and providers to improve drug therapy outcomes. Enhanced systems of cost control and changed models of payment for services could yield considerable savings and marked improvements in patient care at a reasonable cost to payers.

Discussion:

Over the last ten years the costs of pharmaceuticals have increased at an annual rate of approximately 10%—a rate much higher than the annual increases in the consumer price index. Price controls on pharmaceuticals may reduce expenditures or slow the escalation in the cost of drugs in the short-term, but such an approach may have negative consequences on other costs of care and long-term improvements in the prevention and cure of disease. Competitive market forces should be enhanced in order to moderate the costs of this component of the medical care system and should increase quality performance by providers.

Pricing practices of manufacturers and insurers and other payors should reward quality providers, efficient purchasers and economies of scale. Anti-competitive marketing practices which arbitrarily shift costs from one market segment to another should be eliminated. This will insure consistent consumer access to the valuable primary health care services of pharmacists at an affordable cost.

Because a significant amount of money is spent each year for unnecessary drugs and the cost of treating illnesses induced by inappropriately managed therapy, pharmacists are prepared to partner with prescribers and patients to improve medication use in America. The transaction-based reimbursement system currently used for out-patient prescription coverage discourages this approach and must therefore be revamped. An alternative system, which includes incentives for patients and providers to use medications more prudently and for pharmacists to manage the costs of therapy, must be introduced.

Such a system empowers pharmacists to identify the most cost effective drug product which will achieve the intended therapeutic outcome for the patient, insure that the drug regimen is properly selected, and manage the full course of therapy (e.g. patient education and monitoring). Efficient systems for documenting and paying for such services are currently being tested.

MARCH 1993



Coalition for Consumer Access to Pharmaceutical Care

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Association (NPA)

Quality Assurance in the Use of Medications and Pharmacy Services

Position:

Quality assurance programs administered by pharmacists can significantly improve the effectiveness of medications in achieving positive patient outcomes.

Rationale and Impact:

Delivering quality pharmaceuticals and pharmacy services is beneficial in a health care benefit program for two basic reasons. First, emphasizing a quality oriented approach eliminates errors and the additional costs of having to correct drug use problems. Second, providing quality service increases patient and provider satisfaction with the health care benefit program which in turn has a positive effect on patient health outcomes and quality of life.

Discussion:

Quality assessment and assurance programs and the use of quality management techniques must be incorporated into a medication and pharmaceutical care benefit program to increase quality and decrease the costs of care. Quality assessment and assurance programs related to individual patient care should be implemented at local levels through the collaborative efforts of health-care practitioners rather than through centralized systems which cannot address unique patient or provider issues.

Examples of quality assessment and assurance procedures for medication use include drug utilization review, formulary systems, therapeutic drug monitoring by pharmacists and pre-authorized product interchange. Increased patient education and monitoring by pharmacists and the use of patient outcomes analyses are also integral pieces of a quality oriented medication benefit program. Increasingly sophisticated medications and technologies may also suggest the need for a reexamination of the classification system for drugs.

All pharmacists should be allowed to participate in patient care networks based on adherence to quality performance standards. Incentives for patients and providers should be built into the network to insure that quality standards are maintained. Professionals who provide direct patient care should be involved in the design and implementation of the quality improvement techniques used in a program.

Moreover, quality oriented programs must recognize local variations in epidemiology, demography, and practice standards and, most importantly, information related to quality assessment and assurance activities must be held in confidence by all parties.



Coalition for Consumer Access to Pharmaceutical Care

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American College of
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Academy of Managed Care
Pharmacy (AMCP)

American Pharmaceutical
Association (APHA)

American Society of
Consultant Pharmacists (ASCP)

American Society of
Hospital Pharmacists (ASHP)

National Consumers
League (NCL)

National Pharmaceutical
Association (NPA)

Integrated Information Strategies

Position:

Integrated information systems that include pharmacists offer the potential for cost savings and better patient outcomes.

Rationale and Impact:

Integrated information systems that include pharmacists are needed to facilitate the delivery of efficient, high quality care. Current systems lack integration and limit effective communication of information between providers. Better patient-specific information exchange and more efficient claims/administrative management systems will decrease costs, improve the quality of care, and improve patient understanding of the care they are receiving. This must be achieved with adequate protection for patient confidentiality.

Discussion:

Provision of higher quality, more efficient pharmaceutical care requires a more effective integration of pharmaceutical care with other components of the health care system. Current legislative and regulatory mandates require pharmacists to review the appropriateness of patients' drug therapy and provide patient counseling services to improve outcomes of drug use. To meet this obligation, pharmacists must have access to pertinent patient-specific information, including appropriate demographic information and medical history; relevant diagnostic and laboratory data; statement of therapeutic goals or desired outcomes; list of actual or potential drug-related problems, and other therapeutic or clinical monitoring parameters. In addition, the pharmacist must document recommendations on potential therapeutic options and systematically record the services provided.

Many health care providers, particularly in ambulatory care settings, deliver services to patients in isolation from others caring for the same individual. This practice leads to fragmented, duplicative and, in some cases, poor quality care. An integrated information strategy will promote efficiency and increase the quality of care.

Information exchange is also an essential component of efficient administrative (i.e. claim processing) systems. Current health care delivery systems suffer from redundant and non-standardized administration with unnecessary layers of intermediaries in claims management systems. Uniform standards for pharmaceutical care information and claims administration systems should be established which utilize electronic technologies and eliminate inefficient layers of administration. Uniform systems would increase quality assurance capabilities and ease exchange of patient-specific information between providers.

MARCH 1993

A Practical Billing and Payment Plan for Cognitive Services

With this proposed coding system, third party payers can budget and pay pharmacists for providing value-added pharmacy services.

by Dale B. Christensen, PhD, William E. Fassett, PhD,
and G. Amber Andrews, BS Pharm

Recognition and payment for services other than dispensing has been a long-sought goal of pharmacists. Despite demonstrated success in institutional settings,¹⁻³ this goal has remained largely elusive for community pharmacists. Payment predominantly remains linked to dispensing, partly because of tradition and partly because the dispensing of a prescription is tangible evidence of services rendered—and value received.

Third party payers directly pay pharmacies for more than 90% of all prescription services,⁴ and indemnity plans reimburse patients for an additional unknown percentage of prescription costs. Thus, interest in obtaining compensation for cognitive services has emphasized the role of third party payers as the primary economic consumer with whom pharmacists must deal. Seen in this light, the lack of general policies allowing payment for pharmacists' cognitive services is the principal

barrier to achieving pharmacy's economic goals.

Clearly, policies and methods authorizing payment for cognitive services need to be developed. This article seeks to develop both an operational definition of cognitive services or "value-added pharmaceutical services" (VAPSS) and a practical billing and payment plan for community pharmacists.

Seeking Third Party Payment

Recently, Rupp suggested an approach to obtain payment from third party payers for cognitive services.⁵ Concluding that "until generally

accepted policies exist, reimbursement for pharmacy services is likely to be achieved one service and one payer at a time," he provided an example of one approach to obtaining payment. This involved presenting the third party payer with

- A medical certificate of need signed by a physician
- A description of the pharmacy service provided and how



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it related to both medical need and a particular outcome

■ A separate billing statement for the service

Rupp's approach has the virtue of requiring payers to address the concept of paying pharmacists for VAPs that are *not* associated with dispensing a prescription. It also challenges the insurer to explicitly provide a reason for rejecting the claim in the face of a certificate of medical need. Particularly when the service provided is of substantial duration and effort, the amount being billed is likely to justify the expense and effort of documentation by the pharmacist.

An approach different from Rupp's is needed for compensating pharmacists for VAPs *associated with dispensing of prescriptions*. Those services are provided so routinely that they will require a well-defined coding and billing mechanism; documentation by Rupp's method may be cumbersome and cost-inefficient. This article suggests a simple method to provide documentation for payment. This approach will have its greatest benefit for pharmacy networks that can negotiate a system of payment for routinely provided cognitive services, but it is equally applicable to community pharmacists.

The growing body of evidence supporting the value of dispensing-related VAPs^{10,15} has not been sufficient to induce third-party payers to compensate pharmacists who perform them. Payers' reluctance to establish payment policies may arise from (1) a lack of an operational definition of VAPs, and (2) a lack of a workable implementation strategy that allows them to project payments for VAPs and to estimate the economic impact on their programs.

The first step in this approach is to define dispensing-related VAPs and to differentiate them from both routine dispensing services and VAPs not related to dispensing.

Defining Dispensing-Related VAPs

Pharmaceutical care¹⁶ incorporates three major components: dispensing services, dispensing-related VAPs, and non-dispensing-related VAPs.

Pharmaceutical care has been defined as the responsible provision of drug therapy by a pharmacist for the purpose of achieving specific outcomes that improve a patient's quality of life.¹⁷ It is the process through which a pharmacist cooperates with a patient and other professionals in designing, implementing, and monitoring a plan to produce specific therapeutic outcomes for the patient. Pharmaceutical care activities include:

- Directing appropriate, safe, cost-effective drug therapy
- Identifying and preventing potential drug-therapy problems
- Resolving actual drug-related problems
- Providing drug therapy (i.e., dispensing)

Pharmaceutical care may be subdivided into those services *associated with dispensing a prescription* and *other value-added services*. These distinctions are illustrated in Figure 1.

The following definitions attempt to differentiate between the tasks associated with the dispensing of pharmaceuticals and the value-added services performed by pharmacists.

Applicable state statutes and regulations help define dispensing services as:

- Accurately filling a prescription order
- Clarifying incomplete or illegible prescriptions
- Not dispensing orders that a reasonable and prudent pharmacist would recognize as containing *obvious* errors
- Communicating drug use instructions to patients as required by applicable regulations

These services—although they differ from state to state—include the most critical cognitive functions of pharmacists, but they are paid for as part of the dispensing fee.

Cognitive services are services a pharmacist provides to or for a patient or health care professional that are either judgmental or educational in nature rather than technical or informational.¹⁸ These services *may or may not* be related to the dispensing of a prescription. They become *value-added* when their performance is not obligatory under existing reimbursement mechanisms.

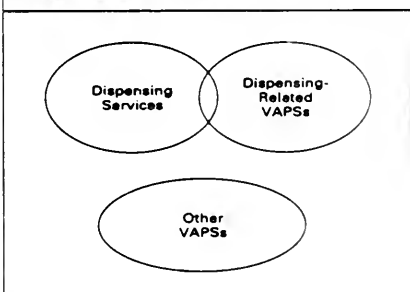
Dispensing-related VAPs extend beyond *routine* dispensing tasks and cognitive activities normally provided and reimbursed as part of the dispensing fee. These services are associated with:

- Monitoring patient use of drugs
- Detecting less than optimal therapy
- Consulting with the prescriber, the patient, or other health providers

Examples of dispensing-related VAPs in the ambulatory setting include: (1) conducting drug regimen reviews to detect clinical problems associated with the prescription about to be dispensed, and (2) selecting the appropriate drug product (e.g., interchange among generically, pharmaceutically, or therapeutically equivalent products).

Figure 1

Pharmaceutical Care



Examples of non-dispensing-related VAPs include:

- Training patients to use blood-glucose-monitoring devices
- Conducting 'brown bag' drug review sessions¹⁶
- Providing academic detailing

In the institutional setting, examples of non-dispensing-related VAPs include:

- Conducting periodic drug-regimen reviews in long-term-care facilities
- Providing in-service training for nurses or other health professionals
- Participating in medical rounds
- Providing discharge counseling

A critical distinction between routine and value-added services arises when the pharmacist detects sub-optimal therapy—that is, therapy that is not cost-effectively meeting the therapeutic outcome desired for a patient but is not so clearly in error that the pharmacist by law must refuse to dispense it. Pursuing a change in such cases requires time, effort, and skills that are not covered by the normal dispensing fee, but—if the pursuit is successful—will result in tangible benefits for the patient and the payer.

A Proposed Coding System

Earlier studies have characterized the range of problems and interventions that constitute dispensing-related VAPs.^{11,13,17,18} Those findings have been combined and organized into a proposed coding scheme that provides a basis for routine reimbursement for dispensing-related VAPs. In this scheme, each problem related to a specific prescription is associated with a pharmacist's intervention and a

reported outcome. The actual code, which we call a Cognitive Service Code, takes the form PPIIRR. PP is the two-digit problem code, II is the two-digit intervention code, and RR the two-digit result or outcome code. The taxonomy and coding scheme is shown in Table 1.

This coding scheme is largely compatible with the Drug Use Review (DUR) Response Codes developed by the National Council for Prescription Drug Programs (NCPDP).¹⁷ However, the two sets of codes serve different purposes.

Table 1

Proposed Coding for Dispensing-Related VAPs (PPIIRR) vs. NCPDP DUR Response Codes

Cognitive Services Codes	NCPDP Response Codes
Problems (PP)	Drug Conflict Codes
01 Suboptimal drug	N/A†
02 Suboptimal dose	LD Low dose HD High dose
03 Suboptimal dosage regimen	N/A†
04 Suboptimal dosage form	N/A†
05 Suboptimal duration of use	MN Insufficient duration MX Excessive duration
11 Therapeutic duplication	TD Therapeutic duplication ID Ingredient duplication
21 Drug-drug interaction	DD Drug-drug interaction OH Alcohol precaution DS Tobacco use precaution
22 Drug-disease interaction	DC Inferred drug disease precaution MC Drug (actual) disease precaution PG Drug pregnancy alert
23 Drug-allergy alert	DA Drug allergy alert
24 Preventable ADR	PR Prior ADR PA Drug age precaution SX Drug gender precaution
25 Drug-food interaction	DF Drug food interaction
26 Drug-lab test interaction	DL Drug lab conflict
27 ADR observed	N/A†
29 Other drug-specific problem	DI Drug incompatibility
31 Patient overutilization of drug	ER Overuse precaution
32 Patient underutilization of drug	LR Underuse precaution
33 Patient communication difficulty	N/A†
90 Other	N/A†
N/A†	CH Call help desk

† N/A= No corresponding code.

The NCDP codes are intended primarily to communicate to the pharmacist any potential problems that can be detected by computers during on-line prospective DLR. Our codes provide additional indicators for pharmacists' *judgmental* activities (such as identifying suboptimal therapy). They also better characterize the range of review activities and outcomes of a pharmacist's intervention. A comparison of the two coding schemes also is shown in Table 1.

In its present form, our classification system provides a

basis for documenting and communicating dispensing-related VAPs to third-party payers. The cognitive services code could also be incorporated in a pseudo-National Drug Code (NDC) (e.g., in the product and package-size fields). This provides a ready means of including cognitive-service claims within a batch of claims for dispensing activities. Possible subcategories could also be developed.

The operational definition of dispensing-related VAPs derives from this classification. Interventions are consulta-

tions of varying duration to resolve problems that arise from the dispensing of a particular drug. (Under this scheme, the number of minutes the pharmacist spends on the intervention is recorded in the quantity field of the claim record.) Third-party payers will be particularly interested in those dispensing-related VAPs that result in a change in therapy or patient behavior.

Third-party payers will undoubtedly vary in their willingness to accept evidence that VAPs reduce direct and indirect health care costs. Some payers may recognize that institutional-based experience can be extended to the ambulatory setting. Other managers, however, may be quite cautious in committing themselves to increased payments to community pharmacy vendors. In the example that follows, a "bottom-line" strategy is presented that may heighten third-party managers' perception of the value of pharmacists' cognitive services. It illustrates a proposed coding scheme that can document direct savings arising from VAPs.

Implementing VAPs—An Example

- A payment formula must
- Be compatible with elec-

Table 1 (continued)

Proposed Coding for Dispensing-Related VAPs

Cognitive Services Codes	NCDP Response Codes
Intervention Activities (II)	DUR Intervention Codes
10 Prescriber consultation	M0 MD Interface
20 Consultation with another pharmacist	R0 Pharmacist reviewed
40 Third party program consultation	
50 Chart review	
60 Literature review/documentation	
30 Patient consultation	P0 Patient interaction
70 Triage	
80 Other	NA†
N/A†	O0 No interface
Result or outcome (RR)	DUR Outcome Codes
01 Change to drug of choice	1E Filled, with different drug
03 Substitute with generic equivalent	
04 Perform therapeutic substitution	
02 Add another drug	N/A†
11 Change dose	1C Filled, with different dose
12 Change dosage regimen	1D Filled, with different directions
	1F Filled, with different quantity
21 Discontinue drug	2A Prescription not filled
22 Do not dispense	2B Not filled, directions clarified
30 No change—patient counseled	1A Filled as is, false positive
31 No change—no counseling	1B Filled prescription as is
	1G Filled, with prescriber approval

* Version 3 Release 2, NCDP Interface Specification; see Reference 17.

† N/A = No corresponding code.

tronic claims transmission requirements

- Be simple to administer
- Provide incentives to pharmacists
- Limit financial exposure of third party plan administrators

Recognizing the difficulty in documenting indirect cost savings (e.g., avoiding outpatient visits, hospitalizations), this example adopts a strategy for compensating pharmacists only for cognitive services that result in a change in drug therapy, regardless of whether the change resulted in a cost increase or decrease. Even the most hard-line administrator may accept the medical need for such changes because to make them the pharmacist must obtain the prescriber's approval.

As noted earlier, research consistently shows that pharmacists identify a potential drug therapy problem in 2% to 3% of all prescriptions dispensed.^{11,13,18,19} Preliminary data from Washington state documented that between 35% and 50% of pharmacists' interventions resulted in a drug-therapy change, saving an average of nearly \$5.00 per prescription.¹² This savings derived largely from interchanging drug products, correcting prescribing errors, and recommending not to dispense a duplicative drug product.

Applying these estimates to projected claims volume can yield enough money to fund a VAPS program. For example, if pharmacists intervene in about 3% of prescription orders, half of these interventions result in drug therapy change, and the direct savings from these changes approaches \$5.00 per

change, we can estimate the total direct savings. In a plan with about 10,000 enrollees processing 45,000 annual prescription drug claims, the total estimated direct savings can be calculated:

Prescription orders processed	45,000
Percent requiring intervention	x 0.03
Percent resulting in drug therapy change	x .50
Average saving per prescription	x \$5
<hr/>	
Budgeted direct savings in drug costs	\$3,375

This amount could be earmarked for paying VAPS claims.

If we assume, for example, that pharmacists file 810 VAPS claims ($45,000 \times 1.8\%$ drug therapy change rate) for which they are paid \$4.50 per claim, we can compare both *budgeted* and *claimed* direct savings in drug therapy with expenditures for VAPS:

Number of VAPS claims paid	810
Payment per claim	x \$4.50
<hr/>	
Cost of VAPS to third party	\$3,645
Budgeted savings in drug costs	-\$3,375
<hr/>	
Budget variance, VAPS fees	\$ 270
<hr/>	
Claimed savings in drug costs	\$4,050
Cost of VAPS	-\$3,645
<hr/>	
Savings over VAPS fees	\$ 405

Under this model, pharmacists would submit claims using the above coding scheme for each VAPS performed that resulted in a change in drug therapy or patient behavior. Assume each claim is paid at \$4.50, as calculated above, to provide a financial cushion and to provide for administrative costs. As part of the pharmacists' documentation of VAPS claims, they would be required to identify the original and modified costs of the prescriptions involved with VAPS claims. Payment would be made after a voucher is filed. This voucher would provide an audit trail to the prescription or patient drug profile involved. A special "labeler code" combined with the cognitive services codes would create a pseudo-NDC code that identifies each VAPS claim. This claim would be submitted *in addition to* a claim for the dispensed product.

A variation of this system would be to establish different compensation rates for VAPSs, depending on the amount of effort expended. For example, problems requiring direct contact with the prescriber would likely take more time to resolve and engender higher payment than problems that did not. Our proposal includes coding to reflect varying duration of consultation and can accommodate differential fees. A sim-

Testing Payment for Cognitive Services

The state of Washington has received a three-year federal grant to test whether payment to pharmacists for cognitive services (1) will significantly increase the number of drug-related problems detected and resolved and (2) is effective in reducing the cost of drug therapy for Medicaid beneficiaries. The University of Washington School of Pharmacy and the state Medicaid agency are conducting the project jointly. This pilot project is one of two drug use review demonstration projects funded last fall by the Health Care Financing Administration under the Omnibus Budget Reconciliation Act of 1990.

The project will identify interest in and barriers to payment to pharmacists for cognitive services, provide pharmacists with training and periodic feedback on counseling activities, study a method of recording and coding claims for cognitive services, and identify prescribing problems that could be discussed by community pharmacists with prescribers. Under the project, pharmacists will receive a cognitive services fee each time a prescription-related drug therapy problem is identified and resolved, resulting in a change in drug therapy.

lar variable fee-for-service system has been employed with moderate success in Quebec under its "pharmacist opinion" reimbursement scheme.^{20,21}

Auditing and Accountability

If pharmacists readily accept this plan and file substantially more claims than anticipated, would this mean the program is successful? Presumably yes. At least it would be a testament to the effectiveness of financial incentives.

Such success, however, has economic consequences. If reserves are depleted before the end of the accounting period, there are at least three viable options. First, compensation could cease until the end of the accounting period. Second, payment could be extended at the discretion of the third party. A strong case could be made that an extension is warranted if the aggregated claimed drug cost savings to date exceeded the total VAPS claims paid (\$405 savings in our example).

A third alternative could be to have the pharmacy network share the financial risk and reward with the third party payer. Any surplus or shortfall could be shared equally between the pharmacy service network and the payer.

Since so much hinges on the amount saved compared to the total VAPS fees paid, it would be prudent to audit VAPS claims. The information on the claim form provides a clear audit trail. In addition, a year-end reconciliation allows two comparisons: as illustrated in our example, variance of VAPS expenditures versus VAPS budget, and actual direct savings in drug costs versus VAPS expenditures.

These illustrative data should persuade third party administrators that payment for VAPSs saved more money than the VAPS reimbursement cost. In addition, the program produced indirect savings by avoiding drug-related problems—at no net increase in costs for pharmacy services. Because a \$4.50 fee produced more savings than VAPS payments, the VAPS fee could be adjusted upwards for the ensuing period.

Limitations

This proposal has some disadvantages as well as advantages. It does not explicitly recognize many types of VAPSs that do not result in a change in drug therapy, such as patient education or counseling to improve compliance. Second, only a modest attempt can be made to correlate the amount of time or effort spent in the VAPS activity with the amount of compensation. Moreover, the amount of payment is fixed, while the amount of time expended will vary (unless differential fees are implemented based on effort level).

Perhaps the proposal's greatest limitation is that payment for dispensing-related VAPSs is calculated only from direct drug cost savings, not the indirect savings associated with the value of cognitive services. In patient populations where there are convincing estimates of indirect cost savings, how-

ever, nothing in this proposal would prevent pharmacy networks from negotiating higher payment rates based on this additional information.

Conclusion

Our proposal offers the clear benefit of explicitly recognizing—through payment—at least part of the dispensing-related VAPSs that pharmacists routinely perform. It conservatively estimates drug cost savings in a way likely to be accepted by third party payers, *because the savings can be validated*. Under our plan, pharmacists would have a financial incentive to selectively identify and resolve problems that have a high probability of resulting in a drug therapy change. Another advantage is that the amount of financial risk to a third party insurer is known and can be budgeted. Further, the financial outlay can be matched to hard dollar savings to the insurer, and there is a clear audit trail and a year-end reconciliation. Finally, the plan allows for equitable adjustments in reimbursement levels for subsequent years.

This model is similar to the model being used in a demonstration project in Washington state (see box, p. 48).

It is essential that pharmacists identify and document VAPSs they provide in everyday practice. While this may seem time-consuming, it is requisite for recognition and reimbursement. Full recognition and payment may occur incrementally and will require a combination of documentation and diplomacy. This plan is a viable approach to documentation and provides a practical basis for successfully negotiating with payers for compensation. It awaits further development, demonstration, and evaluation.

Dale B. Christensen, PhD, and William E. Fussett, PhD, are associate professors, and G. Amber Andrews, BSPharm, is lecturer, School of Pharmacy, University of Washington, Seattle.

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Mr. STARK. Mr. Waspe.

STATEMENT OF ROBERT A. WASPE, SENIOR VICE PRESIDENT, PUBLIC POLICY AND GENERAL COUNSEL, NATIONAL ASSOCIATION OF CHAIN DRUG STORES, ON BEHALF OF COMMUNITY RETAIL PHARMACY HEALTH CARE REFORM COALITION, ACCOMPANIED BY JOHN RECTOR, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS AND GENERAL COUNSEL, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Mr. WASPE. Thank you, Mr. Chairman. I am here today on behalf of the National Association of Chain Drug Stores with my colleague, John Rector of the Community National Association of Retail Druggists. Together we represent the Retail Pharmacy Health Care Reform Coalition, representing 60,000 community pharmacies, employing more than 112,000 community pharmacists who dispense over 2 billion prescriptions annually.

As an opening prefatory comment, Mr. Chairman, your quest for accurate figures on changes in pricing by the manufacturers of pharmaceutical products is also shared by NACDS. So we contracted with the Prime Institute to develop the NACDS prime index.

The NACDS prime index, to our knowledge is the only pure measure of price increases, on a product specific basis, for the 500 top products dispensed.

Mr. STARK. And they show the price, then it goes down.

Mr. WASPE. As a matter of fact, in aggregate, the prices have been going down. However, it is interesting to note the correlation between public interest in pricing practices as it has increased, and the corresponding decrease in the percentage rate of manufacturer price increases.

The latest quarter statistics for year-to-year pricing changes still show about a 6 percent increase for drugs, which compares to about a 3.2 percent increase in the CPI.

In any event, in the over-65 population, an average of 15 prescriptions per person are used annually as compared to an average 7.3 for the overall population. This higher utilization makes the provision of comprehensive pharmacy services all the more crucial to insure appropriate utilization.

Since its inception, the coalition has consistently advocated four core principles essential to any reform of the health care system, including Medicare. These are: the provision of pharmacist services, uniform standards should be established for the management of health care which utilize electronic claims systems and eliminate unnecessary administrative levels, insuring both the public's free access to community pharmacy and the community pharmacy's free access to the marketplace, and elimination of discriminatory pricing practices.

The profession of pharmacy is united in support of these principles, and I have indicated in my written remarks some of the many organizations who have supported these principles. While my colleague, Mr. Rector, will specifically address the issue of discriminatory pricing and the cost savings attributable to our proposals, I would like to briefly expand upon our first three principles.

I think Mr. Webster has largely been on target, along with a number of other witnesses, on the crucial value that pharmacists can play in the distribution of pharmaceutical products. It is the community retail pharmacist standing at the pharmacy counter who is the health care professional seen most often. He represents the best safeguard against drug-to-drug and drug-to-medical condition adverse reactions, misuse and abuse.

Crucial to the proper performance of the pharmacist's job is the availability of relevant medical information. We strongly advocate the establishment of comprehensive databases of patient medical information which can be made available to the pharmacist to perform appropriate drug utilization review prior to dispensing. These uniform transmission standards and availability of databases will also allow for a more accurate and timely adjudication of billing claims and for the determination of percentage copays, where appropriate.

Our third principle addresses the issue of patient access to the pharmacy of his or her choice. In a May 1993 Penn-Schoen poll of 1,003 adults, 84 percent said they want to retain the right to select their own pharmacy. A full 58 percent said this right was very important to them. This right was recognized in the Social Security Act provisions as related to Medicaid and is a stated objective of the President.

The corollary right of pharmacies to have full access to the marketplace is equally important. Plan administrators who arbitrarily shut retail pharmacies out of their network deny to plan members access to the pharmacies of their choice and distort the highly competitive marketplace which currently exists between the 60,000 community retail pharmacies in America. The segmenting of the outpatient prescription marketplace results in weakened competition and cost shifting, the elimination of cost shifting being another objective of the President.

At this point I would like to turn to my colleague, Mr. Rector, to discuss discriminatory pricing.

Mr. STARK. Mr. Rector, proceed.

Mr. RECTOR. Our fourth coalition principle, in summary, is that all pharmacies, irrespective of practice setting, must be able to acquire prescription drugs at the same price subject only to economies of scale such as volume purchasing.

I noted in last week's Congressional Record an insert the chairman had noting that a particular product costs \$1.54 per tablet in San Diego and across the border, 35 cents. We are here to try to draw your attention to the fact that—maybe think of James Baldwin almost as another country—we have that same marketplace within our border. You can go to Oakland or Michigan or Oklahoma or Louisiana or any State in this country and find the same price discrepancy right in our own communities. It is our principal problem in the marketplace. One of the principal objectives of our coalition is to provide for some evenness in the marketplace.

I noted with some interest Senator Pryor's statement to the committee today reads as follows, in part, "Health care reform should put an end to the games that manufacturers have played with providers by offering some lower prices at the expense of others."

What is the impact of such practices? Of course when there is a lower price offered in the one sector, there is a higher price offered in other sectors. That is not only seriously hurting the pocketbooks of all American consumers; it is causing an alarming number of seniors to go without much needed prescription drug medication simply because they cannot afford it.

I would like to highlight that in addition to the multitier pricing that you have heard so much about. These same pharmaceutical corporations and branded companies even refuse to sell to our buying groups. So you hear so much about how decision making is driven by the volume and the like. They don't give us the advantage of volume purchases because that is how they maintain their pricing schemes to assure that the American consumer generally pays the highest prices anywhere in the world.

My last area of comment is to note the savings associated with the package that our coalition submitted to the Clinton administration. In summary, Don Muse did numbers for us over a 5-year period. There is a \$52 billion savings associated with our recommendations. I will focus on the pricing aspect of that savings.

Congressman Levin said earlier that perhaps some of the other witnesses weren't prepared to submit draft language to accomplish your objectives. We could provide that to you this afternoon. We did provide it to the administration earlier this year in March.

You established the so-called AMP in your 1990 Medicaid amendments, so now you know what the pricing structure is in every State. In California you could determine on a product-by-product basis the average price. By bringing the price to the average manufactured price and imposing a CPI over those 5 years, there is nearly \$25 billion in savings.

The other possible source of revenue to achieve financing of the benefit that you are assessing today is to look very carefully at the actual acquisition costs by entities currently buying drugs under the Medicare program, hospitals, HMOs, and the like.

Take a long hard look at the markup between those actual acquisitions and what you are actually paying through Medicare and Medicaid and what the third-party payers are paying. You will note a stark contrast to the 30 to 40 percent markup that is the general rule in a very competitive retail drug marketplace.

I thank you very much. We stand ready to respond to any questions.

[The prepared statement and attachment follow:]

**TESTIMONY OF ROBERT A. WASPE
COMMUNITY RETAIL PHARMACY HEALTH CARE REFORM COALITION**

Mr. Chairman and Members of the Subcommittee, I am Robert A. Waspe, Senior Vice President, Public Policy and General Counsel of the National Association of Chain Drug Stores. I am happy to be here today with my colleague, John Rector, Senior Vice President of Government Affairs and General Counsel of the National Association of Retail Druggists. Together, we are representing the Community Retail Pharmacy Health Care Reform Coalition. The Coalition's members represent the totality of community retail pharmacy, including more than 60,000 pharmacies and employing more than 112,000 community pharmacists who dispense over two billion prescriptions worth approximately \$45 billion annually. Coalition members employ more than one million people.

On behalf of the Coalition, we would like to commend you and the Subcommittee for your leadership on health care issues and your interest in the important subject of providing pharmacy services to our elderly population.

Pharmacy services and pharmacy care should be an integral part of any basic benefit package for Medicare beneficiaries. Millions of senior citizens rely upon prescription drugs as part of a daily health care maintenance program. Moreover, countless studies have shown that effective drug therapy can result in huge health care cost savings by either remediating the disease or infection or halting its progression to a more serious stage.

In the over 65 population, an average of fifteen prescriptions per person are used annually as compared to an average 7.3 prescriptions for the overall population. This higher utilization makes the provision of comprehensive pharmacy services all the more crucial to insure appropriate utilization of prescription and over-the-counter drugs.

Since its inception, the Coalition has consistently advocated four core principles essential to any reform of the health care system, including any changes to Medicare. These principles are:

1. The provision of pharmacists' services is essential to any basic health care plan.
2. Uniform standards should be established for the management of health care which utilize electronic claims systems and eliminate unnecessary administrative layers.
3. Ensuring both the public's free access to community pharmacy and community pharmacy's free access to the marketplace are the best ways to provide pharmacists' services and preserve the competitive market which exists for the provision of those services.
4. Essential to the preservation of a competitive community pharmacy marketplace is the elimination of discriminatory pricing practices by manufacturers of prescription products.

The profession of pharmacy is united in support of these principles. To date, the principles have been endorsed by thirty nine state pharmacy associations representing more than 88% of the nation's pharmacists, twenty six state chain drug associations, in states which represent 63% of the nation's population and 64% of the nation's GNP, the Food Marketing Institute, whose supermarket members dispense nearly \$4 billion in prescription drugs and the American Pharmaceutical Association.

My colleague, Mr. Rector will address with some specificity the issues of discriminatory pricing and how our proposals can provide significant cost savings. I will briefly expand upon our first three principles.

As I have previously stated, the provision of pharmacist services is crucial to Medicare prescription drug coverage. It is the pharmacist, as a member of the health care team, who insures that prescription drugs are used appropriately; who safeguards against drug-to-drug and drug-to-medical condition adverse interactions; and who represents the last defense against misuse and abuse. The community retail pharmacist, standing at the pharmacy counter, is often the only health care professional seen regularly. Therefore, any proposal to provide pharmaceutical coverage must allow and properly incentivize the pharmacist to provide pharmacy care in conjunction with medication dispensing.

Crucial to the proper performance of professional pharmacy services is the ability of the pharmacist to access needed, relevant medical information concerning the patient. The standardization of data bases of medical profiles and uniform transmission standards will allow the pharmacist, whatever or wherever the practice setting, to better counsel the patient. According to the National Council on Patient Information and Education, as many as 25% of all elderly hospitalizations are the result of non-compliance with their prescription therapy. Uniform transmission standards will also allow the immediate adjudication of prescription claims data and give the pharmacist accurate billing information for any copayment which may be required of the patient.

Our Coalition's third principle addresses the important issues of patient access to the pharmacy of his or her choice and pharmacy's access to the marketplace. In a May, 1993 poll of 1,003 adults conducted by the New York research firm of Penn & Schoen Associates, Inc., 84% said they want to retain the right to select their own pharmacy. A full 58% said this right was very important to them. Just as people want to select their doctor, they want to select the pharmacist who will work with them in the proper utilization of their prescriptions. This important right was recognized in the Social Security Act provisions relating to the Medicaid program and is a stated objective of the President under health care reform.

The corollary right of pharmacies to have full access to the marketplace is equally important. Indemnity plan administrators who arbitrarily shut community retail pharmacies out of their pharmacy provider network deny plan members access to those pharmacies and their services. These plans also distort the intensely competitive marketplace which currently exists among the 60,000 community retail pharmacies in America. The segmenting of the outpatient prescription marketplace results in weakened competition and cost shifting. The elimination of cost shifting in the marketplace is another stated objective of the President. The Coalition urges the Subcommittee to take full advantage of the one truly competitive market in health care delivery - retail community pharmacy. The only way to properly do this requires that all pharmacies have the opportunity to fill a patient's prescriptions and to let the consumer decide which pharmacy provides the right mix of service, convenience and price to best meet his or her pharmaceutical needs.

At this point I would like to turn to my colleague, Mr. Rector, to discuss discriminatory pricing and the tremendous cost savings that implementation of our principles can bring to a prescription drug and pharmacy service benefit under Medicare.

We would not have significantly higher prices for most American consumers if we eliminated the unfair discriminatory pricing practices of the nation's pharmaceutical manufacturers. These manufacturers currently sell the same quantities of the same medications at price differentials of 30, 50 70, even 90 percent depending upon the type of pharmacy that is purchasing the products.

As pharmaceutical prices have continued to escalate for more than a decade, gross margins in the nation's community retail pharmacies have continued to shrink, reaching an all-time low of 28 percent in 1992. Of the average \$26.00 prescription price, only 50 cents, or 2 percent, is profit for the pharmacy -- barely enough to stay in business.

The community retail pharmacist is clearly not responsible for rising prescription drug prices. Manufacturers are, and it is their discriminatory pricing practices that are driving up the prices paid by community retail pharmacies and, in turn, by the majority of Americans.

Let me emphasize again that the prices paid by these select purchasers -- hospitals, mail order pharmacies, HMO's, nursing homes, clinics, and others -- are not typically based on volume or economics of scale. Let me also make clear that these lower prices are not being passed on to the consumers, or the payers, in these settings.

What is the net impact of these discriminatory pricing purchases? The lower the price offered to these retail pharmacy competitors, the higher the manufacturer's increase in price will be to the community retail pharmacy. That is not only seriously hurting the pocketbooks of American consumers, it is causing alarming numbers of senior and others to go without much needed prescription medication, simply because they cannot afford it.

To add insult to injury and further assure that community retail pharmacy customers pay the highest prices, brand-name manufacturers steadfastly refuse to extend even economics of scale to community retail pharmacy buying groups. At every turn, community retail buying groups have been turned down by manufacturers when trying to purchase brand-name prescription drug products. These multitier prices are the principal cause of higher prices to community retail pharmacies and to most American consumers.

If fair pricing practices were established -- for example, by adopting the current average manufacturer's price as the price for the product, subject only to legitimate economics of scale, i.e., volume purchases -- the bulk of American consumers would realize significant savings in the cost of their community retail pharmacy services.

Further, by requiring manufacturers to give community retail pharmacy buying groups access to economics of scale in their prescription drug purchases, competition would be enhanced and consumers would benefit.

Given the present condition of our marketplace, it is certainly understandable why the Community Retail Pharmacy Health Care Reform Coalition has included as one of its four principles essential to health care reform (including an outpatient pharmacy services benefit under Medicare) the elimination of discriminatory pricing practices by pharmaceutical manufacturers so that irrespective of practice setting all pharmacists would be able to acquire prescription drugs at the same price, subject only to economics of scale including volume.

Discriminatory pricing practices are driving community retail pharmacists out of business. They are promoting the proliferation of remote, inaccessible, monopolistic systems that do nothing more than distribute products, depriving consumers of the personalized, professional, cost-effective care they have come to expect from their neighborhood pharmacist.

But health care is personal. If it is to remain so, we must ensure that consumers, especially the elderly, continue to have access to their community retail pharmacist -- the most accessible member of the health care team in every neighborhood in this country. To ensure that access and to contain the rising price of prescription drugs, the discriminatory pricing practices of the nation's pharmaceutical manufacturers must be eliminated.

The adoption of our Coalition's principles would yield substantive savings.

According to the most conservative estimates calculated by Don Muse, of the Policy Research Group in Washington, D.C., the Coalition's proposals will generate savings of at least \$52 billion between 1994 and 1998. "Our model has predicted CBO estimates within 5 percent over the last 18 months. All estimates are what we believe the Congressional Budget Office would have scored the savings as", Muse said in his report to the Coalition.

According to the analysis by Muse, the Coalition's proposal to adopt the Average Manufacturer's Price with a consumer Price Index cap would generate five-year scored savings totalling \$24 billion. "The estimates assume that the law would have an enforcement mechanism sufficient to force pharmaceutical manufacturers to obey the law," said Muse in his report.

In addition, the analysis predicted that Coalition-proposed policies for pharmacy services utilization management techniques would generate additional five-year scored savings of \$27.3 billion.

Finally, Muse estimates that the Coalition recommendation of a marketplace pricing strategy for pharmacists' reimbursement—which provides for reimbursement at pharmacist's usual and customary charge, capped at the 90th percentile—would generate additional scored saving of \$700 million.

Proportional savings would be available to Medicare through an outpatient pharmacy services benefit.

The results of this independent study vividly demonstrates that a level playing field in the pharmaceutical marketplace, and policies that take advantage of the cost-effective, professional pharmacy services provided by the nation's community retail pharmacists, have the potential for generating significant cost savings for a national health care reform policy. Government policies that target drug manufacturers' discriminatory pricing policies and guarantee consumers the right to select the pharmacy of their choice allow an already competitive retail pharmacy marketplace to do what it does best—provide high-quality, cost-effective pharmacy care.

The Coalition's health care reform proposal still demands that community retail pharmacists contribute to health care cost containment—as they have for years. However, our proposal truly allows for a shared burden, while at the same time addressing the real source of rising drug costs—drug manufacturer pricing practices.

On behalf of the Community Retail Pharmacy Health Care Reform Coalition, we thank you for the opportunity to appear today and continue to participate in the formulation of a Medicare outpatient pharmacy services program.

NARD

Charles M. West, P.D.
Executive
Vice President

COMMUNITY RETAIL PHARMACY

Health Care Reform Coalition

*The Coalition Representing
Retail Community Pharmacy in America.*

NACDS

Ronald L. Ziegler
President & Chief
Executive Officer

PHARMACISTS BY PRACTICE SETTING**173,000 TOTAL LICENSED PHARMACISTS IN THE UNITED STATES**

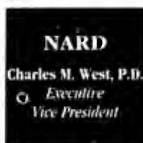
- 112,000 pharmacists employed in community retail pharmacies
- 40,000 pharmacists employed in hospitals and HMO settings
- 5,000 pharmacists in consultant settings
- 5,000 pharmacists in government agencies, research, etc.
- 4,000 pharmacists in industry
- 3,000 pharmacists in academia
- 2,000 pharmacists in mail order
- 2,000 pharmacists in other settings

COMMUNITY RETAIL PHARMACY IN THE MARKETPLACE

- Community retail pharmacy dispenses over 2 billion outpatient prescriptions annually; representing \$46 billion in retail prescriptions

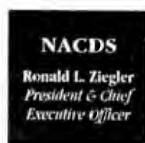
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COMMUNITY RETAIL PHARMACY Health Care Reform Coalition

*The Coalition Representing
Retail Community Pharmacy in America.*



COMMUNITY RETAIL PHARMACY HEALTH CARE REFORM COALITION PRINCIPLES

The National Association of Chain Drug Stores (NACDS) and NARD, the national association representing independent retail pharmacy, which together represent community retail pharmacy practice in the United States, agree that the following concepts are fundamental to any reform of current health care delivery systems:

- (1) The provision of pharmacists' services are essential to any basic health care plan. As the most accessible health care professionals, pharmacists are in a key position to ensure improved and appropriate medication use resulting in decreased overall health care costs.
- (2) Current health care delivery systems suffer from redundant and non-standardized administration. Often, unnecessary layers of intermediaries are involved in claims management systems. Uniform standards should be established for the management of health care which utilize electronic claims systems and eliminate unnecessary administrative layers.
- (3) Ensuring the public's free access to community pharmacy and community pharmacy's free access to the marketplace are the best ways to provide pharmacists' services and preserve the competitive market which exists for the provision of those services.
- (4) Essential to the preservation of a competitive community pharmacy marketplace is the elimination of discriminatory pricing practices by manufacturers of prescription products. All pharmacies, irrespective of practice setting, must be able to acquire prescription drugs at the same price, subject only to economies of scale, including volume.

(Adopted February 11, 1993)

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PRINCIPLES OF PHARMACY SERVICES AND PHARMACY CARE IN HEALTH CARE REFORM

NACDS

Ronald L. Ziegler
President & Chief
Executive Officer

In recognition of strong evidence that pharmacy services and pharmacy care add value to patient care and reduce overall health care costs, the Community Retail Pharmacy Health Care Reform Coalition endorses the following principles as critical factors necessary to maximize the role of pharmacy services and pharmacy care in a reformed health care system:

1. Pharmaceutical products and pharmacy services and care should be a basic core benefit under health care reform.
2. Enhanced pharmacy services and the proper management of patient drug use can generate significant overall savings.
3. Professional pharmacy services go beyond merely dispensing a pharmaceutical product and include the following professional services:
 - Establishment and maintenance of a Patient Profile System;
 - Drug utilization review (DUR) and screening;
 - Patient monitoring;
 - Patient counseling and offering to counsel patients;
 - Intervention and problem resolution; and
 - Drug product selection.
4. Pharmacy services ensure that patients receive the maximum benefit from drug therapy and that drug-related problems are identified, resolved and prevented.
5. Pharmacists must be empowered and encouraged to exercise their professional expertise in making medication-related judgments in collaboration with other health care providers to maximize patient outcomes.
6. Pharmacists must have access to relevant patient information to support their professional judgment and provision of patient services.
7. Mandatory use of the uniform national electronic transmission standard will maximize the ability of pharmacists to provide thorough drug utilization review and determination of appropriate patient pharmacy services to achieve both service quality and cost containment goals.
8. Development of quality assurance programs, designed and implemented at local levels through a collaborative process, will enhance the quality of pharmacists' services.
9. Evaluation studies should further document the added savings pharmacy services contribute to patient drug use therapy.
10. Continued assurance of patient confidentiality is essential in the provision of pharmacy services and pharmacy care to individuals.

March 31, 1993

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NACDS

Ronald L. Ziegler
President & Chief
Executive Officer

Summary Cost Analysis of \$52 Billion In Savings From Principles Advocated by Community Retail Pharmacy Health Care Reform Coalition

The Community Retail Pharmacy Health Care Reform Coalition, which is composed of the National Association of Chain Drug Stores and the National Association of Retail Druggists, requested an independent analysis of the cost-effectiveness of the Coalition's health care reform principles. The analysis was conducted by the Policy Research Group of Washington D.C. and directed by Don Muse, long-time fiscal health care analyst with the Congressional Budget Office.

Total economic impact of the Coalition's principles would produce an estimated "scored" savings of \$52 billion between 1994 and 1998. Scored estimates of savings factor in circumstances that undermine cost savings potentials and therefore provide a highly conservative prediction of cost savings. Specifically, the analysis shows that:

- Adoption of the coalition's principles calling for an end to manufacturers' discriminatory pricing practices and adoption of the Average Manufacturers' Price with a consumer price index cap would generate a five-year scored savings totalling \$24 billion.
- Adoption of the Coalition's proposal for pharmacy services utilization management techniques would generate additional five-year scored savings of \$27.3 billion.
- Adoption of the Coalition's recommendation of a marketplace pricing strategy for pharmacists' reimbursement, which provides for reimbursement at pharmacist's usual and customary charge, capped at the 90th percentile; would generate additional scored savings of \$700 million.

April 26, 1993

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ENDORSEMENTS OF COMMUNITY RETAIL PHARMACY HEALTH CARE REFORM COALITION PRINCIPLES

State Retail Associations' and Chain Drug Committees' Endorsements:

Alabama Retail Association
Arizona Retailers Association
Arkansas Grocers & Retail Merchants Assn.
California Retailers Association
Colorado Retail Association
Delaware Association of Chain Drug Stores
Florida Retail Federation
Georgia Retail Association
Illinois Retail Merchants Association
Indiana Retail Council, Inc.
Association of Iowa Merchants
Kentucky Retail Association
Louisiana Retailers Association

Michigan Merchants Council and Associates, Inc.
Minnesota Retail Merchants Association
Retail Association of Mississippi
Missouri Retailers Association
Montana Retail Association
New Mexico Retail Association
Retail Merchants Association of Nebraska
North Carolina Retail Merchants Association
Ohio Council of Retail Merchants
South Carolina Merchants Association
Tennessee Council of Retail Merchants
Texas Retailers Association/Texas Federation of
Drug Stores

State Pharmacy Associations' Endorsements:

Alabama Pharmaceutical Association
Alaska Pharmaceutical Association
Arkansas Pharmacists Association
California Pharmacists Association
Colorado Pharmacists Association
Connecticut Pharmaceutical Association
Florida Pharmacy Association
Georgia Pharmaceutical Association
Idaho State Pharmaceutical Association
Illinois Pharmacists Association
Indiana Pharmacists Association
Iowa Pharmacists Association
Kentucky Pharmacists Association
Louisiana Pharmacists Association
Maine Pharmacy Association
Maryland Pharmacists Association
Massachusetts State Pharmaceutical Assn.
Michigan Pharmacists Association
Mississippi Pharmacists Association
Missouri Pharmacists Association

Nebraska Pharmacists Association
New Hampshire Pharmacists Association
New Jersey Pharmaceutical Association
North Carolina Pharmaceutical Association
North Dakota Pharmaceutical Association
Ohio Pharmacists Association
Oklahoma Pharmaceutical Association
Oregon State Pharmacists Association
Pennsylvania Pharmaceutical Association
Pharmaceutical Society of the State of New York
Rhode Island Pharmaceutical Association
South Carolina Pharmaceutical Association
South Dakota Pharmaceutical Association
Tennessee Pharmacists Association
Texas Pharmaceutical Association
Utah Pharmaceutical Association
Virginia Pharmaceutical Association
Washington State Pharmacists Association
Wisconsin Pharmacists Association

June 18, 1993

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**The Costs and Consequences
of Drug Noncompliance**

NACDS

Ronald L. Ziegler
President & Chief
Executive Officer

- Noncompliance with drug therapy costs 20 million workdays and \$1.5 billion in earnings annually in the United States.
- Drug noncompliance is the cause of:
 - 10 percent of all hospital admissions
 - 25 percent of hospital admissions among the elderly
 - 23 percent of all nursing home admissions
 - \$8.5 billion in excess hospitalization costs annually
 - Significant outpatient costs
 - Absenteeism from work and decreased job productivity
- An estimated 39 percent of adverse drug reactions requiring hospitalization are caused by improper medication use.
- As many as half of all patients fail to take their medications as directed.
- Approximately 10 percent of patients fail to have their prescriptions filled; as many as 30 percent fail to have their prescriptions refilled
- Studies show that, by the time patients get from the doctor's office to the pharmacy, they have forgotten half of the doctor's instructions about their prescribed medication.
- Noncompliance includes failing to have a prescription filled or refilled as instructed by a physician, failing to take all of the medication when instructed to do so, failing to take the medication when scheduled, taking more or less than prescribed, or taking a drug in combination with food, medications, or under conditions warned against by the physician or pharmacist.
- As many as 50 percent of patients with high blood pressure stop taking their medication during the first year, and after three years, only a third are still compliant with their prescribed drug regimen. In one study, one in four patients who had difficulty complying with antihypertensive therapies were hospitalized as a result of noncompliance.
- The cost of the medication is small compared to the cost of treating the results of noncompliance. In one study the cost to treat noncompliance was four times the annual drug cost to the patient.

March 31, 1993

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Mr. STARK. Many of you have all talked with Mr. Magaziner about this. Maybe you have got him straightened out. We are waiting to hear what effect—I would like to just follow along.

I am curious about the PMAs fascination with managed competition. Arguably—well, they all belong to the bohemian club let's say, the CEOs of the big manufacturers associations, so that would be easier for them to deal with prices than the guys running the HIPC's.

That maybe doesn't make—figure out, you know, you hate doing it for a nonprofit or eleemosynary reasons. And I keep wondering what is the gimmick.

Have you ever been to Elwood's house in Jackson Hole?

Mr. MOSSINGHOFF. No, I have not.

Mr. STARK. How many of the pharmaceutical manufacturer guys do you think are in that club?

Mr. MOSSINGHOFF. I believe that—

Mr. STARK. Half dozen maybe?

Mr. MOSSINGHOFF. We have our executive vice president, Mr. Allnutt, I believe you know, has been there for a meeting; and I believe two other members of the PMA—I know two other members of the PMA are part of the Jackson Hole group.

Mr. STARK. Do you think they all paid the hundred thousand bucks to go? Some folks do.

Mr. MOSSINGHOFF. I don't know. PMA did.

Mr. STARK. It sort of sounds like the real good pinkos of my youth always were—bought into this conspiracy theory of bankers and manufacturers meeting in some exotic foreign place to destroy the world and join up with Daddy Warbucks and get all the money in the world and put the rest of us away. But I must say that the conspiracy theory gets my paranoia boiling when I do think—I spent a lot of time at Jackson Hole.

I was thinking the other day, the movie *Roger and Me*, of going up and knocking on the door with my video camera; but I figured Elwood would never survive that if his heart, at the high attitude, was not in good shape.

But what is there in managed competition that attracts you all? What is the shtick? Give me an example of any place in the world where it exists?

I mean, what are we talking about? Give me a good capsuled synopsis of what you would see not in East Bay where we have a lot of HMOs but in Kansas City, Missouri, or Kansas.

How do you see managed competition? How do you see the State of Kansas—what laws?

Mr. MOSSINGHOFF. As I point out in my statement, Mr. Chairman, the managed care system is here.

Mr. STARK. Competition. Managed competition.

Mr. MOSSINGHOFF. Well, managed competition, I would submit, is not a defined term yet. I don't know whether the President is going to use that term or not.

Mr. STARK. You guys do.

Mr. MOSSINGHOFF. We use it coming out of the Jackson Hole model. We would agree with the Jackson Hole model. It is the one the lingo came from. I think HIPC has been now changed to Alliances. But by whatever name, it is the idea. First, we support it.

We believe that of the estimated 72 million people that don't have prescription drug coverage. Now, obviously most of those get pharmaceuticals, but they pay it out of their own pocket. We think they should be covered for pharmaceuticals. I think everyone on this panel agrees pharmaceuticals are the most cost-effective form of therapy. The board of directors of PMA believes that.

So we believe they should be covered. We are in favor of health care reform. We are not in favor of a single payer or a Medicare model. We think that would really dry up the research in our industry, certainly.

I have some background in the aerospace industry, and I think all research would be done like the aerospace industry. All cost plus using government tax money, not the private \$13 billion that we are investing now in research.

So given the need for health care reform—

Mr. STARK. You know how to get a guy where it hurts, don't you?

Mr. MOSSINGHOFF. The Jackson Hole model, we believe, and our companies have a lot of experience dealing in very tough managed care settings. As I have indicated, a study by the Boston Consulting Group, show that a large percentage of pharmaceutical products sold in the United States are now sold in that setting. We understand how it works. We can compete in it.

The board of directors, I think, is pretty collegial in terms of its positions, but they are fierce competitors in the marketplace. We have seen how it works, and we think that is the best model to preserve the free market and yet have overall comprehensive health care reform with cost containment in it.

Mr. STARK. Let me just suggest to you for a minute that occasionally in another life—and it dawns on me with great irony that I may be in a position of creating one of the larger HIPC's in the country if—as I suspect, the many communities will not do it, either they won't be able to, the State legislature won't meet; they won't get around to it; it will fall to somebody's lot. But the District of Columbia is another job that I have. I may have to preside over the committee that will design the HIPC for the District of Columbia. I might even go on the board, but let's think a minute about that.

So the HIPC is designed, and there are four or five accountable health plans, Kaiser is here, Georgetown, George Washington; and what if the HIPC board, thereby, created or demanded there be a formulary in all your worst fears and they said, that is what you must do?

You can only sell your pharmaceuticals in the District of Columbia to these five accountable health plans, and they are going to be able to negotiate these prices based on whatever rules they set.

Do you still support managed competition under that?

Mr. MOSSINGHOFF. I would say, Mr. Chairman, that that would be a real perversion of the idea of the Jackson Hole managed competition—having a HIPC or even above that, in the case of the District, maybe perhaps the whole district-wide, above that, the Federal Government setting a formulary. I can't think of anything—

Mr. STARK. No. This would be the HIPC itself setting it.

Mr. MOSSINGHOFF. The Jackson Hole plan says the HIPC is a pool, and they will compete with AHPs. PMA starts with the propo-

sition that the patient should get what the doctor prescribes. I think that is the fundamental principle that most people would agree with.

But if there are to be formularies, or as Dr. Wagner talked about, preferred lists, where you have some appeal mechanism or whatever, that should occur at the AHP level, not at the HIPC level.

Mr. STARK. Does Kaiser have a formula?

Mr. MOSSINGHOFF. Let's say you do have the five you mentioned—and I assume other doctors would get together and form—

Mr. STARK. Let's go to my hometown. Does Kaiser have a formulary?

Mr. MOSSINGHOFF. I assume they do.

Mr. STARK. Do you have any complaint with that? They provide pharmaceuticals to most of their members; and under the risk contract that they are about to open up in northern California, I presume they will. You got any complaints the way you deal with Kaiser.

Mr. MOSSINGHOFF. I can't answer that specifically because I am not familiar with the Kaiser formulary, how it operates. If it operates in a flexible way so at the end of the day the patient gets the drug that the doctor determines is best for the patient, we would support that.

Mr. STARK. Not only gets it. Gets it free.

Mr. MOSSINGHOFF. Better yet. But the drug the doctor prescribes then, it seems to me, that is something our industry is very used to working with.

Mr. STARK. You don't mind doing it with Kaiser. You just mind doing it with me.

Mr. MOSSINGHOFF. Nothing personal.

Mr. STARK. No, I understand. OK. The managed competition thing is just a little side bar here. But I am puzzled because I have the utmost respect for the pharmaceutical industry's ability to make money. I am astounded by it as a matter of fact. I have to figure that you all see something in this managed competition. It isn't a charity move.

Mr. MOSSINGHOFF. What we see is the companies—

Mr. STARK. I can figure out Elwood and those guys. They got the real racket coming. But you guys all got to go to their seminars to learn how to run these things and then the costs really go up. You should have paid the hundred thousand bucks early on and demanded free training. But instead of getting \$20,000 a speech, those guys are going to really stick it to you.

Mr. MOSSINGHOFF. The theory behind—and obviously a lot of work needs to be done between the theory and practice—the Jackson Hole proposal is eloquent in its simplicity. Those who do the best job providing health care will be the most successful at the AHP level, at the level of the alliance you pool resources.

Mr. STARK. And we are all a product of our experience. So he goes to Stanford University, arguably one of the finest medical centers in the world; but the people from East Palo Alto don't go there certainly for their preventive care. Therein are some of the problems. Let me try this.

Mr. MOSSINGHOFF. Let me say, it is the fact that in our industry, the most successful in their research and development and who do the best job ultimately, best serve the patient who needs the new medication. In my testimony, I talk about the \$400 million worth of uncured diseases that afflict the elderly that are not yet curable. Some have treatments. There are no cures for those diseases. They cost \$400-plus billion a year.

The companies in our industry that do the best job of inventing the best medications for patients are the most successful financially. We are used to working in that setting.

If the Jackson Hole model of managed competition carries that into the nationwide program, those companies that do the best job in serving patients, whether they are AHPs or whether they are the pharmaceutical industries, will succeed. And we are willing to buy into that.

We believe our industry is successful enough—we are number one in the world in the U.S. pharmaceutical industry, no dispute about that. We believe if we are successful enough to serve patients well enough, that we will be able to make sufficient profit in that industry to keep the industry on its track.

Mr. STARK. But you don't think you can do it with a Medicare type system? That exceeds your abilities?

Mr. MOSSINGHOFF. The Medicare?

Mr. STARK. Yes. You can't continue to make money and be premiere in the world if you had to deal with something as complex as Medicare.

Mr. MOSSINGHOFF. The rebate system under Medicare is a real hit. It went up from \$3.5 billion. They originally estimated over 5 years—it is a small percentage of the market.

Chairman STARK. Say it was all the market. You are telling me the industry is not capable of operating. If we went to a Canadian style system, all the MBAs and Ph.D.s in the industry couldn't figure that one out?

Mr. MOSSINGHOFF. I believe that if you had the rebate system in Medicaid for all of health care in the United States you would have companies going Chapter 11 very quickly. I think our companies cannot afford that.

Chairman STARK. So what you are telling me is your talent is a mile wide and an inch deep. You can operate when you can control the market but the minute you have to deal with some complicated regulations the industry falls apart. Is that what you are saying?

Mr. MOSSINGHOFF. If we are paying \$1 billion now on 12 percent, \$1.1 billion is the latest HCFA estimate in 1992 on 10 to 12 percent of the market, you multiply that by 10 more to get to the market on a very small market—we are talking a \$40 or \$50 million market in the United States, I don't think we could afford \$10 or \$12 billion worth of rebates in a \$44 billion market.

Last year, our profit margin was 11.5, lower last year, according to Fortune Magazine, than the previous 5 or 6 years. You couldn't pay that kind of money back to the government if you do the back of the envelope arithmetic.

The Canadian system is improving. They have now enacted a decent patent law.

Chairman STARK. Oh no, they didn't. You guys got it in the North American Free Trade Agreement. We are going to try to knock it out. But that wasn't Canada. That was the pharmaceutical manufacturers in the United States sticking it to the people in Canada by getting the White House to put that cockamammy thing in the Free Trade Agreement, the worst kind of interference in international trade I have seen in years.

We are here to protect the American public, but to watch you guys rip off the Canadian public in that sanctimonious manner is just—

Mr. MOSSINGHOFF. I believe you overestimate our power.

Chairman STARK. I don't overestimate—it is a fact—the social consciousness of your industry leaves something to be desired. To suggest the Canadian patent system which rips off the Canadian consumer—

Mr. MOSSINGHOFF. Mr. Chairman, it is a fact that if your constituents had to rely on medications from the time Canada took away patents in 1969, your constituents would get 25-year-old-technology because there were no drugs invented there since 1969. That is all right for Canada, which is a small country, but it is not all right for the Congress to try to push that kind of force onto the world's most successful high technology industry.

Chairman STARK. And most profitable. I would ask others of you—you didn't address the managed competition issue, Mr. Waspe. How would you see your industry reacting to what you presume managed competition might be? Where do you see yourselves fitting into that?

Mr. WASPE. We see managed competition as an essential effort to introduce the fine American tradition of competition to many segments of the marketplace who have previously not met such a concept. We are somewhat unique in the health care marketplace because we are intimately familiar with the concept of competition.

You have 60,000 community pharmacies competing on a daily basis with each other. We support the concept of competition and bringing this concept to noncompetitive fields. We do not believe it is necessary to impose artificial means of competition upon our marketplace by cramming down additional layers of managed competition on retail pharmacies.

We support taking the best of what the current system offers, that is, establishment of electronic claims management systems, drug utilization review, open competition between pharmacies to provide services, aggressive use of formularies.

The testimony from OTA was on point. The key to controlling drug costs is effective implementation of formularies.

We believe that manufacturers should compete for placement on formularies based on their price to the entire marketplace, not in the limited, walled off segmented marketplaces that they are currently playing in, all of which is at the expense of the people who buy their prescriptions in our stores.

Chairman STARK. In your stores, do your pharmacists routinely and voluntarily advise physicians and patients on cost-effective alternatives? And if you don't, why not? What prevents that. Do physicians resent it? Are there conflicts of interest? Is there not enough time?

Mr. WASPE. The current reimbursement system does nothing to provide incentives for pharmacists to be involved in therapeutic substitutions. That, unfortunately, is a reflection of the reimbursement methodologies developed in the last 15 to 20 years which are trying to change the practice of pharmacy from a profession to a commodity distribution industry, something we oppose.

We believe that pharmacists are more than willing and want to be involved in the management of appropriate drug therapy, but there is nothing to provide incentives to do that.

Yes, doctors sometimes strongly resent pharmacists calling them up and suggesting more cost-effective therapeutic alternatives. Yes, it is a significant additional cost factor to pharmacists to get involved in that.

The OBRA regulations, by HCFA's own admission, added \$1 to \$2 to the cost of dispensing a prescription in the United States; yet we have not received a single additional penny for performing those additional duties.

Chairman STARK. I am going to yield to Mr. Brewster at this time, who has a time commitment.

Mr. BREWSTER. Thank you, Mr. Chairman. I have a bill up in 10 minutes in another committee.

Mr. Mossinghoff, you represent an industry that has been very dynamic, an industry that can arguably take credit for the quality of life we enjoy in this country today and the longevity of life to some extent. This industry is responsible for the many advancements, the many new drugs that have been created by the pharmaceutical manufacturers through the years.

Many people today owe a lot of their quality of life to that. Yet the public perception is much different. The public perception is that the companies are ripping them off, et cetera.

Why do you think it is that way?

Mr. MOSSINGHOFF. I think part of it is the fact that a large portion of the public—and that is a problem that PMA I think has and has not successfully solved—doesn't know that our industry invents new drugs. They think new drugs somehow come out of the university system or the National Institutes of Health. They aren't aware that 95 percent of all new drugs come out of the research-based pharmaceutical industry.

If you don't start with the major premise that we discovered the drug out of the whole cloth—and again I think PMA should confess we have not been successful in getting that point across—the amount of money you have to pay for it becomes very irritating to you.

Second is I think the fact that more than double the percentage of Americans who don't have health insurance don't have prescription drug coverage. Hospitals, for example, using round numbers cost about \$300 billion a year and yet out of pocket \$10 billion. We are at \$44 billion a year, but out of pocket over \$20 billion. So there is a mismatch there between the cost of the pharmaceutical versus what comes out of pocket and the cost that comes out of insurance.

I am like everyone else, as long as the insurance is going to pay, I don't get out a sharp pencil. I think those two factors combined really hurt the industry in its public perception.

Mr. BREWSTER. So they don't pay the anesthesiologist out of their pocket, but they pay for their Zantac when they go to the pharmacy out of their pocket.

Do you think the fact that so many people travel today and have the opportunity to go to other countries being able to buy drugs at much lower prices in other countries affects that? What is the rationale for companies selling products in other countries at maybe a third of the price here? What is the rationale for that?

Mr. MOSSINGHOFF. PMA does not get involved in pricing decisions of companies.

Mr. BREWSTER. I am asking for your opinion.

Mr. MOSSINGHOFF. Take Mexico. Their standard of living, their per capita income is between one-seventh and one-tenth of that in the United States. It is a poor developing country.

We applaud what the administration is trying to do to change that, but the fact is their cost of living and per capita income is about one-seventh of what it is in the United States. You are then faced with a dilemma. You are the executive of a major company. Do you give them a break on price compared with a State in the United States and let them have the benefit of the drug? You will make sure when you price that you will cover additional costs, the manufacturing and delivery cost, packaging costs—all that you are going to cover.

I think most companies have decided to do that and they do sell the drugs in Mexico for less than they do in the United States. That covers manufacturing, but there is no conceivable way you could cover a research-based industry's efforts in R&D with that kind of pricing. So the dilemma is do you deprive the Mexican people of this drug or do you price it the same as you do in San Francisco?

Each company decides. I think I would opt in favor of selling it to people in Mexico for something approaching their per capita income's ability to pay.

Mr. BREWSTER. I have an argument with your argument there. The people who take most of the medication in this country, many senior citizens, are not at the average per capita income. They are far below it. Many people who are retired and live in my area have \$600 or \$700 a month Social Security income. They are not anywhere close to the average per capita income in the United States.

So you argue per capita income in the United States when you have a Ross Perot making whatever that changes the average as opposed to the average income of Mexico or Venezuela. That is different. I think they better rethink that argument.

Mr. MOSSINGHOFF. I can't speak for every country, but there is a dilemma I think. Take Bangladesh, where their standard per capita income is one-one hundredth of what it is in the United States. Do you sell the drug there or not?

I am not arguing with your statement. I think it leads right into our position, and that is we want everybody to have as part of the basic benefits package, we want them to be covered for the pharmaceutical benefits.

Mr. BREWSTER. I was in Venezuela last year and bought an NSA1 at 44 cents a tablet at retail. I worked in a pharmacy the week before I went and knew the cost here was \$1.16. The people that we

dispense that to in rural Oklahoma, many are about the same income level as some of the people in Venezuela. I believe there are some inconsistencies in the theory of doing it on the per capita income of a country. That makes no sense.

Another thing—a lot of the pharmacies in Texas right now are getting a lot of their products from Mexico as opposed to direct from a manufacturer. If NAFTA occurs, what is to keep everybody from just buying through Mexico?

Mr. MOSSINGHOFF. NAFTA does not in any way change the laws governing the patent laws of the United States.

Mr. BREWSTER. It may before it is through.

Mr. MOSSINGHOFF. As currently written, NAFTA does not affect the laws on parallel imports or, as patent lawyers refer to it, exhaustion of patent rights. Patents are basically territorial. So a U.S. patent is enforced only in the United States, a Mexican patent only in Mexico, and so importing something from Mexico to the United States would violate the patent rights in the United States.

Mr. BREWSTER. Even though it is the same product produced by the same American company marketed under the same trade name?

Mr. MOSSINGHOFF. That is correct.

Mr. BREWSTER. Why do some companies rebate or discount in the United States on something other than volume? For instance, a medication that may be sold to one particular HMO for a particular price and yet is available to retail pharmacies who buy through maybe a buying group of 5,000 stores, yet it is sold to one party at 20 percent of the total cost, 80 percent discount of what it is to someone else, why do they do that?

Mr. MOSSINGHOFF. I am at a great disadvantage. I don't get involved in our companies' specific decisions. I read the Wagner studies and the rest, and the indication there is that the HMOs in their system have a way of influencing physician prescribing practices and the neighborhood pharmacist does not.

Mr. BREWSTER. Is that through therapeutic substitution?

Mr. MOSSINGHOFF. It is through a formulary system which we hope would be flexible enough, to go back to my major premise, that says every patient should get what the doctor prescribes. But a tightly run HMO, they do have formularies and they do influence the prescribing doctors' practices based on price sensitivity.

Mr. BREWSTER. So if they have therapeutic substitution, is that something PMA supports?

Mr. MOSSINGHOFF. No. We would support a system where if the doctor and the pharmacist decide together this is the best medication, that is a fine use of both professionals to do so. We would oppose a system where a pharmacist on his or her own would change a prescription ordered by a doctor without consulting with a doctor in every instance, particularly in an outpatient neighborhood setting.

Mr. BREWSTER. But HMOs do that and that is one method of controlling medications and that is why you give them better prices?

Mr. MOSSINGHOFF. I believe HMOs have a system whereby the doctor initially decides based on whatever advice the doctor gets from his or her management, decides initially to prescribe a drug.

Mr. BREWSTER. So the doctor is managed rather than care being managed?

Mr. MOSSINGHOFF. I believe so in a HMO setting, certainly a staff HMO.

Mr. BREWSTER. So not necessarily for the product that might be best for the illness, but for the product that might be available to the HMO?

MR. MOSSINGHOFF. I believe that every doctor, if the doctor decides this drug is best and, if the system is tailored right, will ensure the patient gets that drug. I have enough faith in the medical profession I believe that would be the case.

Mr. BREWSTER. I do too. I have great faith in the medical profession. Mr. Rector alleges that their buying groups don't have access to the same prices as the others? Is that correct?

Mr. MOSSINGHOFF. I don't know. Indeed we wouldn't tolerate a discussion in PMA about that. We would not let one company discuss the fact that they did or didn't provide something to a buying group in Kansas City. Our general counsel would stop that immediately.

Mr. BREWSTER. If that is correct, in your opinion, is that proper?

Mr. MOSSINGHOFF. I think—

Mr. BREWSTER. To sell something for 8 cents for one company and yet somebody that buys more might have to pay forty-four cents for it? Would that be proper?

Mr. MOSSINGHOFF. I am in no position to comment.

Mr. BREWSTER. You also said that the rebate system if it were expanded to Medicare would be something the companies couldn't handle. That would indicate then that there is a big divergence between the minimum price and what you are pricing to everyone else if the rebate, which is part of the difference, was something that couldn't be handled; is that correct?

Mr. MOSSINGHOFF. All I did was a "back-of-the-envelope." I took the \$1.1 billion and if Medicaid is 10 or 12 percent, I expanded that and said they couldn't afford—in a \$44 billion market—rebates of \$12 billion.

Mr. BREWSTER. The rebate occurs from the difference in the average price and best price; am I correct?

Mr. MOSSINGHOFF. No. The rebate is based upon the best price.

Mr. BREWSTER. The rebate occurs between the average price and the best price.

Mr. MOSSINGHOFF. For some companies, there are two other factors. One factor is there is a minimum rebate. I believe it is now 15.7 percent. That is a minimum. You could have a straight price across the board, one price and you still have to pay 15.7 percent rebate to Medicaid, and that is also influenced by the CPI factor.

If your prices have gone higher than the Consumer Price Index for that drug, there is an add on amount.

Mr. BREWSTER. The initial premise in OBRA 1990 was that it was a percentage of the difference between average price and best price.

Mr. MOSSINGHOFF. Or a set discount starting at 12.5, then 15; now it is 15.7.

Mr. BREWSTER. If the company chose to go that route.

Mr. MOSSINGHOFF. If the company had an absolute straight-level price across the board, they still have to pay 15.7 percent to Medicaid. It is the greater of those two.

Mr. BREWSTER. Mr. Webster, I noticed in your discussion, I didn't see anything concerning access to providers. Under your scenario, should every provider have access to customers?

Mr. WEBSTER. Our coalition, speaking on behalf of the Coalition for Consumer Access to Pharmaceutical Care, believes that the health care system must be reorganized to more effectively utilize the skills and experience of pharmacists, the most accessible of health professionals.

Mr. BREWSTER. So then you would support whatever we do in managed competition or whatever, the people setting a rate and allowing any provider that wants to participate that is duly licensed in that State the right to participate?

Mr. WEBSTER. Having the opportunity to gain access to participation, meeting the requirements of the AHP, yes.

Mr. BREWSTER. So your coalition supports all providers having the opportunity to participate?

Mr. WEBSTER. Yes.

Mr. BREWSTER. There is conflicting information about how serious senior citizens are in terms of which services they would most like to see added to Medicare. How important is prescription drug coverage in your opinion to senior citizens?

Ms. GOLODNER. I think it is very important and I think it has been proven that senior citizens are paying out of pocket too much for prescriptions and over the counter and for services that they really need. So I think they are willing to pay for—would like to get that benefit.

Mr. BREWSTER. How important do you think counseling by the pharmacist is as far as the total scheme of pharmaceutical therapy?

Ms. GOLODNER. I think it is very important because of the problem of the interaction of drugs and drugs, over the counter and prescription drugs that consumers experience, and also to assure compliance with the therapy that has been prescribed by the physician or that is suggested by the pharmacist.

Mr. BREWSTER. So you think that an electronic DUR system could be very helpful in the total scheme of quality of care in the future?

Ms. GOLODNER. It can be. We would also like to see medical smart cards used by consumers so they have information at hand so that they can have a choice of where they go to get their prescription filled.

Mr. BREWSTER. Mr. Haddad, you said, with reimbursement differentials such as these, pharmacists have little or no incentive to dispense generics. On the previous page, you used an example, Medicaid now reimburses pharmacies \$58.32 for a hundred tablets of the Enderol brand of brand of propranolol but only \$2.33 for the generic version.

You are talking about the cost part of the reimbursement, not the fee part?

Mr. HADDAD. The fee is not included in that.

Mr. BREWSTER. Pharmacists I know much prefer to dispense a generic because they have fewer dollars out—

Mr. HADDAD. That is also a prevalent feeling among some pharmacists because of the cost of the overhead to keep the brand name. A lot of them, like the chain drug stores, will have their pharmacists call up and change a drug from a brand to a generic, but there are a number of pharmacists who are like the person I cited. He said he put somebody in the cab and sent him back to a doctor to get a brand name and still made a larger profit than using a generic.

Mr. BREWSTER. But on the basis of a cost of \$58.32, in Oklahoma I believe the reimbursement fee is AWP minus 10 and a half plus \$5.14, he would have in a reimbursement about \$53 on a \$58 cost plus \$5.14 cents. However, if he is able to get 15 or 16 percent discount in his buying structure, he is able to make a little money.

Whatever you are looking at, you are talking about less than 10 percent reimbursement. On the other route, when you go \$2.33 plus \$5.14, he is able to get a decent reimbursement. Most Medicaid systems are 6 weeks in reimbursing you to start with.

Mr. HADDAD. If you are lucky.

Mr. BREWSTER. I find very few who I think are interested in dispensing the higher-priced product, at least in my State which has an AWP discount in the pricing structure.

Mr. HADDAD. That is not universal. That is an accurate example, but it depends where you are and whether you are part of a chain, but that is an accurate representation, and that is the statement of a pharmacist before a congressional committee.

Mr. BREWSTER. Mr. Rector, you mentioned that you don't have access to the same prices that others do, that even though your buying group might buy more quantity of medication. Why is it that way? Why would it not be that you would have access to as good a price if you bought as big a quantity?

Mr. RECTOR. I am glad you asked that. I was going to try to jog Mr. Mossinghoff's memory. If you are selling low to some of our competitors, and they maintain their profitability by selling at the highest price to retailers and to the bulk of American consumers, no wonder they don't want to have to sell on volume and economies of scale to our buying groups. It is the way they maintain their profitability.

It is the other shoe of their discriminatory pricing scheme. One shoe is the multitier pricing and the other one is the refusal to sell to our buying groups. If we could buy on the basis of economies of scale including volume, then the bulk of American consumers would not be experiencing the ravaging price increases that they have seen in the last decade.

There was speculation a moment ago about what PMA might or might not do. Putting aside PMA, I can vouch to you that just within the last month in the States of New Mexico, North Carolina as we speak, and New Jersey, the major members of PMA and all the folks they can hire, are out in force to prevent State Legislatures from attempting to enact the kind of equitable pricing legislation that we are talking about. So I would be shocked if at least a legislative discussion didn't surface on these kinds of issues at the meetings of the PMA.

Mr. BREWSTER. Mr. Mossinghoff, I notice you have in your testimony that managed care grew explosively in the 1980s. Is it coincidental that the huge increases in pharmaceutical products, increases in their price occurred at the same time, or is it the very price differential that Mr. Rector is talking about?

Mr. MOSSINGHOFF. I think probably the price increases of the 1980s, which do not describe the industry of today, that probably came directly from a couple of forces.

One, there was a period of time when the FDA was taking probably the longest time in history to approve new medicines. It was a time when the Patent Term Restoration Act, the Waxman-Hatch law, was enacted. The Waxman-Hatch law was a two-act economic play. The first act was to speed to the market generics so our companies lose, the bottom falls out of their market the first year or two after patent life. That was a new phenomenon in the market.

Before that, you could find product life that lasted for 15, 20, 25 years. Under the Waxman-Hatch Act, generics were speeded on the market. That was the period of time during which they were speeded on the market.

The other part of it was patent term restoration, which the industry supported. That is the second act of the play. That has come into effect in the last year or two because it didn't come into effect economically until the patent otherwise would have expired.

So this two-act economic play came in, and the bad first act part of it from an economic point of view occurred immediately following the Waxman-Hatch Act. The other part is now phasing in and we are getting longer patent life as a result of the formula within the patent extension bill.

Mr. BREWSTER. So you would say there is no connection then?

Mr. MOSSINGHOFF. I can't say that. I am at a disadvantage. I am being very honest. We don't permit discussions on what companies do and how they decide what their pricing is.

Mr. BREWSTER. Then you have no personal opinion?

Mr. MOSSINGHOFF. My personal opinion is the major effect was because of this two-act economic play that occurred following the 1984 Waxman-Hatch Act.

Mr. BREWSTER. Maybe you could have a CEO of a company come and explain this to me.

Mr. MOSSINGHOFF. I would be pleased to arrange that if we can.

Mr. BREWSTER. Mr. Chairman, I very much appreciate the opportunity to do this. I probably missed presenting my own bill in another committee, but you don't have an opportunity to talk to these groups at one time very often, so I appreciate the opportunity.

Chairman STARK. The gentleman brings a great deal of insight to the committee in his particular knowledge of this area and I appreciate Mr. McCrery's forbearance here.

Would you like to get in while we have another 10 minutes here?

Mr. MCCRERY. No, Mr. Chairman. I have enjoyed watching all the dogs in the hunt. Thank you.

Chairman STARK. I want to thank all of you who have participated, particularly Mr. Mossinghoff, who with no knowledge of his client's activities has done a wonderful job of shielding them from having to answer for any of their practices. I must say that is—I sure hope that nobody ever starts to compare their phone tallies

when the Justice Department decides to—it sounds like if any of these guys ever talk to each other they will be off at the Boesky tennis ranch improving their backhand. When you play in high-stakes games, I guess you take high-stakes risks.

I thank all of you. This process will proceed and we will look forward to hearing from you again when we hear from the administration as to what they recommend and I suspect then we will be going over the same ground again.

The hearing is completed. Thank you very much.

[Whereupon, at 2 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

WE DON'T HAVE TO KEEP PAYING THROUGH THE NOSE
TO GET VITAL PRESCRIBED MEDICATIONS INTO OUR BODIES

A Written Statement on Health Care Reform:
Expansion of Medicare Benefits to Include Prescription Drugs
for the Subcommittee on Health, Committee on Ways and Means
U.S. House of Representatives

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21 June 1993

SUMMARY

1. Firm controls on drug spending are vital today; they are even more important for tomorrow, because they will signal those developing new medications that they must consider affordability as well as efficacy.
2. The United States General Accounting Office has found that Canada's mix of regulation and concentrated buying power contains overall drugs prices well below U.S. levels.
3. But few Americans are aware of the savings we could win by adopting Canadian (or some Western European) methods. Public awareness could be heightened by diffusing specific and concrete information on how much would be saved in individual states or on individual medications.
4. To illustrate, we estimate that prescription drug spending in Massachusetts in 1992 could have been cut by \$380 million-- from \$1,556 million to \$1,186 million, a saving of about 25 percent. Similar estimates could be developed for other states. We also provide information on the annual dollar savings that individual patients would enjoy on specific medications.
5. We call for a combination of publicity and action at both state and national levels to increase public awareness of this problem and to show that it can be solved through intelligent public action.

INTRODUCTION

Total spending on prescription medications in the United States is already too high. And if we fail to set a ceiling on total spending on prescription drugs in the United States, we will open the door to even greater financial disaster.

In health care, our nation has long paid too much attention to promises of voluntary cost controls and to preparing mechanisms and incentives to contain costs. We have avoiding the sharp and simple steps of limiting spending while requiring universal coverage.

(Health care is not the only such arena. American policies on reducing the trade surplus Japan extracts from us have relied on promises of changes in behavior. We have not demanded or threatened a ceiling on the trade deficit we are willing to suffer.)

Some say that placing a ceiling on prescription drug spending would put many Americans at medical risk. This is inflammatory nonsense, a modern parallel to waving the bloody shirt in post-Civil War politics. Our nation already spends enough on medications-- as it does on health care overall-- to provide the care that works to the people who need it.

A spending cap would force drug companies to make better choices-- choices that save lives and ease suffering at prices we can afford for the long haul.

Unless our nation erects effective limits on total drug spending and on drug prices, drug companies will continue to ignore the costs of the new medications they develop. Why should they pay attention to costs today, since physicians' prescribing habits and the companies' own marketing efforts assure the drug companies something close to cost reimbursement for their products?

But if a ceiling on total drug spending is enforced, drug companies will see that they must balance efficacy and affordability when developing new medications. (Researchers and marketers make choices about which new drugs are developed, and about where the frontiers of medical ignorance are pushed backward.) In so doing, drug companies will act in the public interest, because they will develop more of the drugs we can afford.

AN ILLUSTRATIVE ANALYSIS

The following example estimates savings from drug cost and price controls that might be expected for one state and for a few individual medications. It also sketches a crude method of estimating total spending on prescription drugs in a state. The example proceeds by posing and answering seven questions.

1. Question: How much is spent on prescription drugs in Massachusetts?

Answer: We estimate that \$1,566,071,000-- over \$1.5 billion-- was spent on prescription drugs in Massachusetts in 1992.

This figure was not readily available; we had to estimate it indirectly in several steps.

Step 1. The Access and Affordability Monitoring Project estimates that \$1,994 million was spent in Massachusetts in calendar year 1992 on "drugs and other non-durables," the category established by the Health Care Financing Administration that includes prescription drugs. This was 8.2 percent of total Massachusetts health spending of \$24.3 billion.¹

Step 2. Nationally, 59.2 percent of spending on drugs and other non-durables went to prescription drugs. But this category includes only "spending for drugs and over the counter products... purchased from retail outlets," including mail order firms and HMO pharmacies.² Prescription drugs dispensed in hospitals, nursing homes, and physicians' offices are excluded.

Step 3. In hospital year 1991, all Massachusetts hospitals together provided 878,000 admissions, 2,876,000 emergency room visits, and 9,078,000 other outpatient visits.³ We assume, for these calculations, that the average inpatient was charged \$250.00 for drugs per admission, that the average emergency room visitor received \$10.00 in drugs per visit, and that the average non-emergency outpatient visitor received \$5.00 in drugs per visit (this last group was mixed; it includes many patients who receive no medications and a smaller number who may receive costly medications, such as those used for chemotherapy). We conservatively assumed that hospital use in 1992 remained at 1991 levels, even though our evidence suggests that it has risen somewhat. We assume further that the average nursing home patient received \$5.00 worth of prescription drugs daily. All of these assumptions measure drug costs at the prices paid by patients or insurers. They rest in part on conversations with physicians and hospital pharmacy directors, and should be regarded as reasonable guesses.⁴

Relying on these assumptions and guesses, we estimate total spending on prescription drugs in Massachusetts at \$1,566,071,000. To summarize:

Estimated Prescription Drug Spending in Massachusetts, 1992

<u>Category</u>	<u>Prescription drug spending</u>	<u>Assumptions</u>
Retail and mail	\$1,180,248,000	59.2% of \$1,994 million
Hospital inpatient	219,500,000	878,000 admissions @ \$250
Hospital emerg room	28,760,000	2,876,000 visits @ \$10
Hospital other outpt	45,390,000	9,078,000 visits @ \$5
Nursing home	92,173,000	18,434,690 patient-days @ \$5
TOTAL	\$1,566,071,000	

2. Question: How much would a Canadian-style system using concentrated buying power and drug price regulation have saved citizens of Massachusetts?

Answer: About \$380 million in 1992 alone.

We obtained this result by taking estimated 1992 Massachusetts prescription drug spending of \$1,566,071,000 and calculating how much it would have cost in Canada in that year, relying on the U.S. Government Accounting Office's study showing that Americans, on average, pay 32 percent more for prescription drugs than Canadians at wholesale.⁵

This calculation entailed dividing Massachusetts prescription drug spending by 1.32, resulting in a 1992 dollar figure for Massachusetts prescription drug spending under a Canadian system of drug regulation of \$1,186,417,000. This sum is \$379,654,000 less than the \$1,566,071,000 actually spent on prescription drugs in Massachusetts in 1992. To summarize:

1992 Massachusetts prescription drug spending	\$1,566,071,000
minus cost of drugs under a Canadian-style system	- \$1,186,417,000
equals savings under a Canadian-style system	= \$ 379,654,000

3. Question: Are U.S. drug prices highest in the world?

Answer: Apparently.

-- According to the U.S. General Accounting Office, a market basket of 121 frequently prescribed drugs would cost 32 percent more in the U.S.A. than in Canada, at factory prices.⁶

-- Savings on many drugs would be much greater. We calculate that Massachusetts residents who use certain drugs throughout the year would have saved very substantial sums if Canadian methods of controlling drug prices had been employed here.⁷ For example:

<u>drug</u>	<u>cost per year</u>			
	<u>U.S.</u>	<u>-</u>	<u>Canada</u>	<u>= saving % saving</u>
Premarin	\$131.36		\$50.14	\$81.22 61.8%
Synthroid	\$76.61		\$20.27	\$56.35 73.5%
Ortho-novum	\$239.88		\$131.08	\$108.80 45.4%
Lopressor	\$313.83		\$138.86	\$174.97 55.8%

<u>drug</u>	<u>cost per year</u>			
	<u>U.S.</u>	<u>-</u>	<u>Canada</u>	<u>= saving % saving</u>
Inderal	\$321.13		\$91.49	\$229.64 71.5%
Coumadin	\$189.76		\$101.48	\$88.29 46.5%
Diabeta	\$205.06		\$97.18	\$107.87 52.6%
Corgard	\$646.71		\$394.33	\$252.37 39.0%

4. Question: Have U.S. drug prices been rising rapidly?

Answer: Yes.

-- Another U.S. GAO study found that between 1985 and 1991 the median increase in prices for 29 widely-used prescription drugs was 145 percent, more than twice the medical consumer price increase and nearly five times the rise the overall consumer price index.⁸

-- According to a WCVB-TV Channel 5 (Boston) editorial last fall, the "share of Medex [the main Massachusetts Medigap plan's] premiums which goes for prescriptions has tripled in the last six years...."⁹

5. Question: Why do U.S. drug prices rise so rapidly?

Inaccurate answers, provided by drug companies to U.S. GAO:¹⁰

- "increased research and development... or operating costs"
- expansion or improvement in manufacturing capacity
- changes in "prices for comparable therapies"
- "increased product value"
- cost of "physician and patient education programs"
- "increased exposure to product liability litigation"
- shorter time to recoup investments, because generics are licensed quickly
- "inflation"

6. Question: Why do U.S. drug prices rise so rapidly?

Real answer:

Alone among the industrial democracies, the United States does not take firm and direct steps to restrain either the price of prescription drugs or their total cost to people. As a result, we also subsidize other nations. They use their buying power to obtain price cuts, set prices through regulation, or set "reference prices" that key reimbursement to the lowest-cost generic or therapeutic equivalent. Consider these actions taken elsewhere:

-- In Canada, according to the U.S. GAO, lower drug prices are largely attributable to a combination of provincial governments' use of concentrated buying power and the federal government's price regulations,¹¹ not to differences in manufacturers' costs between the two countries. One Canadian expert points also to Canada's requirement that drug companies license their products fairly quickly to other manufacturers, to spur price competition.¹² Ironically, this requirement would be repealed by the North American Free Trade Agreement.

-- The French government sets the price of prescription drugs. Because it subsidizes the price of drugs to patients, it has a clear stake in holding down the price at which it buys from manufacturers.

-- In Sweden, the National Insurance Board has effective control over the price of prescription medications.¹³

-- The German government is setting "reference prices" for prescription drugs, generally equal to generic prices. The Germans also group medications by their therapeutic active ingredients, and German sickness funds reimburse at the lowest price in each group, although physicians may still prescribe what they wish.¹⁴ The Dutch have provided for something very similar.¹⁵

7. Question: What should individual states do?

Answer: Prepare to take action guaranteed to contain drug prices.

The international experience shows that simple and direct government action is guaranteed to hold down spending on prescription drugs. (More mere promises are worthless.) Federal action would be helpful. The Canadian experience shows that a combination of federal and state action could be successful.

But with federal efforts uncertain today, each state should prepare to act on our own by exploring all techniques legally available. Possibly, successful state action could build foundations for even more effective and simple federal initiatives.

Possible state actions could include:

- price controls

- the establishment of a state buying authority that would serve as monopsony buyer for all prescription medications; it would not hold wholesale stocks but merely negotiate the prices at which drugs move from manufacturers to wholesalers and retailers

- joining together with other states to seek even greater buying power

I hope that these thoughts are useful to members of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives.

Notes

1. To calculate these figures, we relied heavily on data and analyses compiled by the Health Care Financing Administration, the Bureau of the Census, and the Lewin/ICF consulting firm.
2. Katharine R. Levit, Helen C. Lazenby, Cathy A. Cowan, and Suzanne W. Letsch, "National Health Expenditures, 1990," *Health Care Financing Review*, Vol. 13, No. 1 (fall 1991), p. 34.
3. American Hospital Association, Hospital Statistics, 1992-93 edition, Chicago: The Association, 1992, table 5-C.
4. All dollars reflect estimates of prices actually paid by consumer or third parties. Volumes of hospital care were taken from 1991; these were assumed to persist during 1992. Volumes of nursing home care were taken from 1986, date of last Massachusetts Department of Public Health Survey; relatively little change is believed to have taken place subsequently. It would be desirable to obtain better data, but these should serve for present purposes, to give a ballpark estimate of current drug costs and future potential savings.
5. We assumed that wholesale and retail prices moved in parallel.
6. U.S. General Accounting Office, Prescription Drugs: Companies Typically Charge More in the United States Than in Canada, Washington: GAO, September 1992, GA/HRD-92-110, p. 2.
7. Our analyses applied the differentials identified by the U.S. GAO to discounted retail prices from various Boston-area chain pharmacies. U.S. General Accounting Office, Prescription Drugs: Companies Typically Charge More in the United States Than in Canada.
8. U.S. GAO, Prescription Drugs: Changes in Prices for Selected Drugs, Washington: GAO, August 1992, GAO/HRD-92-128.
9. "Grappling with the Medex Problem," WCVB-TV Channel 5 Editorial, 30 September 1992.
10. U.S. GAO, Prescription Drugs: Changes in Prices for Selected Drugs, p. 5.
11. U.S. GAO, Prescription Drugs: Companies Typically Charge More in the United States Than in Canada, pp. 15-17.
12. Bradford Buxton, National Pharmaceutical Strategy, Health and Welfare Canada, telephone conversation, 12 February 1993.
13. Letter from Brita Cronquist, Swedish Embassy, 14 December 1992.
14. John K. Iglehart, "Germany's Health Care System," part 2, New England Journal of Medicine, Vol. 324, No. 24 (13 June 1991), pp. 1750-1756.
15. Cornelis M. de Vos, "Cost Containment on Drugs in the Netherlands: The First Experiences," Netherlands Ministry of Welfare, Health and Cultural Affairs, 21 September 1992.

DAVID PRYOR, ARKANSAS, CHAIRMAN

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United States Senate

SPECIAL COMMITTEE ON AGING
 WASHINGTON, DC 20510-8400

Statement of Senator David Pryor (D-Ark)
 Chairman, Special Committee on Aging

hearing of the
 Subcommittee on Health
 Committee on Ways and Means
 United States House of Representatives

Medicare Outpatient Prescription Drug Benefit

June 22, 1993

Mr. Chairman. Thank you for holding this very important hearing on the need for an outpatient prescription drug benefit under the Medicare program. For many older Americans, buying medications often means that they have to make unfortunate choices between food and medications, or paying rent and obtaining their drugs. There are two major causes of this unacceptable situation: a lack of adequate prescription drug insurance coverage for older Americans, and twelve years of skyrocketing prescription drug prices at the manufacturers' level.

It is unlikely that the Medicare program will, in the short term, be folded into the new health care system. If this is the case, then the Administration and the Congress will need to consider the additional benefits that could be provided in the fee-for-service Medicare program to reflect the package of standard health benefits being provided to the under-65 population. If the standard benefits package contains prescription drug coverage, then the development of a Medicare drug benefit under the current fee-for-service program must be seriously considered.

I recently sent a discussion paper to Mrs. Hillary Rodham Clinton, who was asked by our President to chair the National Task Force on Health Care Reform that will make recommendations on restructuring our nation's health care system. In this paper, I made several recommendations about the structure of a potential Medicare outpatient prescription drug benefit, which I would like to summarize now:

Medicare Deductible

The prescription drug deductible in the Medicare Catastrophic Coverage Act (MCCA) of 1988 was designed to cover only 17 percent of Medicare beneficiaries each year. However, there are many beneficiaries who have high out-of-pocket drug costs which may not be "catastrophic" as defined by the deductible, but which are "catastrophic" as a percentage of their income. This fact should be kept in mind when structuring the deductible level.

Pharmaceutical Cost Containment

Medicare's outpatient prescription drug program will be the largest fee-for-service drug program in the entire market. As such, it should use its leverage to negotiate lower prices with drug makers.

The MCCA was enacted without any specific pharmaceutical cost containment mechanisms for the program. In fact, even as the final provisions of MCCA were being negotiated, estimates of drug program costs in the outyears were rapidly escalating. That is because MCCA was exactly the type of fee-for-service program to which manufacturers have traditionally increased prices to offset the discounts that they negotiate with managed care plans and hospitals. A new Medicare drug benefit could meet the same fate unless cost containment provisions -- both for drugs currently on the market and new drugs -- are included in the final package.

If one assumes that the majority of the pharmaceutical market will be subject to competitive forces, such as volume purchasing and therapeutic drug formularies, Medicare will literally become the last bastion of unrestricted pricing for drug manufacturers. Without specific cost containment mechanisms for Medicare, manufacturers will take advantage of that fact, just like they forced Medicaid to pay the highest prices for drugs for decades until 1991.

Medicare beneficiaries and the federal treasury should not become an open spigot of funds to support drug manufacturers' exorbitant prices and profits. Without Medicare cost containment, system-wide drug costs will not be contained, they will just be shifted to Medicare. Health care reform should put an end to the games that manufacturers have played with providers by offering some lower prices at the expense of others.

One cost containment option would be to require manufacturers to provide discounts to the Medicare program equal to a certain percentage of the Average Manufacturers' Price (AMP). An additional rebate could be required of the manufacturer if drug prices increase faster than the rate of inflation (CPI). Reimbursement for manufacturers' products under any government program could be contingent on signing an agreement with the Secretary of HHS to provide these rebates to Medicare. There is precedence for this drug cost containment approach in the Medicaid rebate law of OBRA 1990, and in the Veterans Health Care Act of 1992.

Another option is to require that manufacturers negotiate with the Medicare program over the price of their drugs, especially new drugs. The fundamental concepts underlying "managed competition" -- the approach that the drug industry has endorsed as the way to contain pharmaceutical costs -- are negotiation and competition. Therefore, Medicare should be able to use these same mechanisms to contain Medicare drug program costs.

Encouragement of Generic Drug Dispensing

Any Medicare drug benefit should encourage the dispensing of generic drugs when these drugs are medically appropriate. There is substantially more brand name prescribing throughout the health care system, where generics could be dispensed, especially in the current Medicaid program.

Medicare would save hundreds of millions of dollars by encouraging as much generic dispensing as possible. Reimbursement incentives should be provided under Medicare to encourage the dispensing of generic drugs. In addition, a uniform generic substitution override procedure should be adopted, enforced, and audited by the Health Care Financing Administration (HCFA).

A Medicare drug pricing guide should be provided to physicians and pharmacists about the relative cost of drug regimens for various diseases within therapeutic classes. This approach will make health care providers more sensitive to the cost of various courses of drug therapies for Medicare beneficiaries.

Drug Use Review

Because of the multiple number of prescription medications commonly taken by older Americans to treat chronic conditions, the Medicare drug benefit should include a comprehensive program of drug use review (DUR). The DUR language enacted in OBRA 90 for Medicaid recipients could be used as a model for Medicare's DUR program. This includes a program of prospective and retrospective review, and educational interventions. Providing payment for medication management, especially among high-risk Medicare patients, should be explored.

Mr. Chairman, these are just some ideas on how we could design a potential Medicare outpatient drug benefit. The Medicare outpatient prescription drug benefit that we develop should provide our nation's seniors with the life-saving drugs that they need, while it assures that the program controls costs and improves the quality of medication outcomes. I look forward to working with you to achieve these goals in the months ahead. Once again, thank you for calling this important hearing and focusing attention on this issue.



HARVARD MEDICAL SCHOOL
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July 2, 1993

Janice Mays, Esq.
Chief Counsel and Staff Director
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, DC 20515

Dear Ms. Mays:

Enclosed, as requested by Congressman Pete Stark's office, is a copy of a letter/statement to the Health Care Reform Task Force. The letter summarizes the policy implications of our research on access, costs and outcomes of prescription drug benefits for the low-income elderly and chronically ill.

We wish to place this written statement into the record of the June 22, 1993 hearing on prescription drug coverage in Medicare conducted by the Subcommittee on Health, Committee on Ways & Means, U.S. House of Representatives.

Our statement and those of my colleagues on the Harvard Medical School faculty are based on research performed by us, and do not necessarily represent the views or opinions of Harvard University.

Please let us know if you need any further information in connection with this statement. We can be reached at the letterhead address and telephone number(s).

Sincerely,

Stephen B. Soumerai, Sc.D.
Director
Associate Professor

Dennis Ross-Degnan, Sc.D
Assistant Professor

Thomas McLaughlin, Sc.D
Instructor

cc: Pete Stark
enclosure

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Ms. Hillary Rodham Clinton
The White House
Washington, DC 20500

Dear Ms. Clinton:

The purpose of this letter is to bring to your attention some recent research published by our group which may be relevant to your mandate to draft a comprehensive plan for health care reform. Inevitably, such a process will lead to a consideration of coverage and cost-containment policies related to prescription drugs. While representing only about 10% of the nation's health care bill, medications are powerful agents for improving health outcomes for many somatic and psychiatric conditions. Prescription drugs are widely used; 75% of all physician visits end with at least one drug prescription. Prohibitive costs of new and highly effective agents combined with growing evidence that medication misuse or under-use can pose significant risks to public health have elevated the fervor of the scientific and policy debates about prescription drugs in recent years. Government and private policies affecting access to medications can have an important impact on health status and health system costs, particularly for low-income, vulnerable populations who cannot always afford to pay for medications themselves. For the frail elder with congestive heart failure or the asthmatic child, economic access to medications may prevent unnecessary suffering and costly hospitalizations.

As an independent research team at Harvard Medical School, our group of health services researchers, clinicians, epidemiologists and statisticians has been studying the outcomes and determinants of both over- and under-use of medications for over ten years. Our goal in this letter is simply to make you aware of the results of a few studies which are most relevant to your deliberations, and to make several tentative recommendations regarding prescription drug policies. We would also be happy to respond to other related needs for data which might be of use in your deliberations.

Unintended Effects of Drug Payment Limits in Low-Income Populations

As you know, Medicaid programs provide insurance for some (but not all) low-income elderly, disabled, and chronically ill populations with significant medical needs. Medications are "optional" Medicaid benefits (although they are certainly essential to a low-income patient with diabetes or heart failure). Consequently, states vary considerably in their drug coverage policies. The effects of changes in state reimbursement policies can be tracked in large populations through careful longitudinal analyses of claims data in which it is possible not only to evaluate the effects of policies on prescription drug use, but also to begin to understand the impacts of drug coverage on health outcomes and use of more intensive health services in low-income populations generally.

The first of a series of studies published in the New England Journal of Medicine (attachment 1), attempted to evaluate both the intended and unintended impacts of suddenly-introduced payment limits and cost-sharing on elderly and disabled people in New Hampshire (the study state) and New Jersey, which maintained full coverage during the three-year study period. We identified a high-risk group of 860 multiple-drug recipients, who were predominantly female and elderly or disabled. Time-series results indicated that:

- This group's average number of monthly prescriptions dropped from 5.2 to 2.8, representing a 46% reduction in filled prescriptions.
- Reductions were not confined to only "ineffective" or "inappropriate" drugs. There were significant decreases in use of all medication categories studied, ranging from life-sustaining to marginal.
- Declines in use of highly effective agents for diabetes, heart conditions and mental illness were particularly worrisome. For example, drops of about two-thirds in average reimbursed doses of one vital medicine, insulin, were documented among diabetic patients.
- When the three-drug cap was lifted and replaced by the milder \$1.00 per prescription co-payment policy, use of effective drugs returned almost to baseline levels.
- The degree to which patients' essential medication regimens were maintained or interrupted depended largely on provider awareness of a loophole in the regulation allowing prescription duration to increase.
- Based on additional computerized pharmacy data outside of the Medicaid program, out-of-pocket payments in this low-income population were minimal and did not substantially offset reductions in benefits.

Effects of Drug Payment Restrictions on Institutionalization in Nursing Homes and Hospitals

Because of the potential adverse clinical and economic effects of such policies, we obtained additional funding from the U.S. Agency for Health Care Policy and Research to further investigate the effects of such reimbursement limits on patient outcomes among a vulnerable population of Medicaid recipients who were receiving medications chronically for one of several major illnesses (e.g., heart disease, asthma or COPD, and diabetes). Again, we followed about 2000 such patients in New Hampshire and New Jersey, mostly women, for over three years (before, during and after the payment cap). All medications examined in the study were identified by an expert panel as essential, maintaining independence and preventing sometimes life-threatening complications. The results, published in the New England Journal of Medicine in late 1991 (attachment 2), indicated that:

- The three-drug reimbursement cap significantly increased the likelihood that previously independent frail elderly would enter nursing homes, often permanently.
- Rates of institutionalization in nursing homes were almost identical in both states in the five months before the cap; after the cap was instituted, when the number of essential medications filled dropped by 35%, the study population in New Hampshire was twice as likely to enter nursing homes as those in the identically defined comparison population.
- When the three-drug cap was lifted in the study state, the excess rate of nursing home admissions disappeared.
- As expected, people with multiple illnesses who were regularly taking three or more essential medications were most likely to enter the nursing home during the cap (120% increased risk).
- We also observed an increased risk of hospitalization of 20%; however, this effect was not statistically significant due to incomplete data.
- Conservative estimates of the cost of excess nursing home care indicated that any drug cost-savings achieved by the three-drug cap were offset by increased costs of institutionalization after a one-year period. This does not consider the associated losses of independence and quality of life.

Factors Associated With Vulnerability to Payment Restrictions

In follow-up analyses in our study cohort of chronically ill individuals in New Hampshire, we investigated which factors were associated with increased risks of losses of essential medications and subsequent nursing home entry. Highlights of these unpublished results include:

- Individuals who suffered the greatest loss in use of essential medications had the highest rates of institutionalization. Those whose use dropped by 30% or more were twice as likely to enter a nursing home as those who maintained 90% or more of their previous use.
- Patients with multiple chronic illnesses suffered the greatest reductions in drug use, specifically, those who were being treated for mental health problems, chronic pain, or diabetes.
- Patients seen in organized care settings like clinics or group practices suffered smaller reductions in drug use, presumably because care-givers were better able to appropriately communicate about and circumvent the regulation.

The Effects of Drug Reimbursement Restrictions on the Chronically Mentally Ill

The chronically mentally ill and, in particular, schizophrenics, often depend on psychotropic medications to maintain adequate functioning in the community. In fact, numerous studies have indicated that many individuals would still be confined to state psychiatric hospitals without the advent of anti-psychotic drug therapy. The purpose of this study was to determine whether Medicaid data sets could be used to identify reliably schizophrenic populations, track outcomes of policy changes in this group, and determine effects of the reimbursement caps on quality of care and outcomes. This research in progress has indicated:

- Computerized diagnostic markers can be used to identify reliably populations of non-institutionalized schizophrenic patients.
- For patients receiving care at community mental health centers, the medication reimbursement cap shifted costs of medications for chronically ill patients from the federal-state Medicaid system to the state-funded community mental health system.

Again, these data question the economic and clinical rationality of reimbursement limits due to the reductions in access to effective medications among the chronically mentally ill, the disruptive effect on patients and the health systems due to cost-shifting, and increasingly complex and fragmented delivery systems.

Implications of Such Research for Pharmaceutical/Health Care Reform

While the above data, published in the most influential medical journals in the U.S., have clear implications for state drug coverage policies, we are afraid that we were not aggressive enough in disseminating results directly to policy makers. For example, about one year after our second NEJM study on the unintended effects of reimbursement caps on institutionalization, both then-Governor Clinton and the governor of North Carolina presided

over the implementation of medication payment caps which were even more restrictive than New Hampshire's policy. While severe fiscal constraints and time pressures often prevent the careful consideration of available, published evidence on these policies, they do not alter the likelihood that such policies negatively impacted elderly, disabled and other chronically ill citizens, increased institutional care, and increased overall health expenditures for these vulnerable individuals.

When the above NEJM study received the 1992 Scientific Article of the Year award from the national Association for Health Services Research, Dr. Jinnat Fowles, the Vice President of the Park Nicollet Medical Foundation, stated during the award ceremony, "The study examines the results of a piecemeal approach to policy as it affects the most vulnerable population, the frail elderly, and it exposes the unforeseen consequences of well-intentioned but simplistic approaches. This study has broad policy implications, beyond drug utilization."

It is important, therefore, in your attempts to seek solutions to even more complex health care crises, that your task force be fully cognizant of both the potential positive and negative effects of specific policies, based on findings from credible research. This is admittedly not an easy task, given the informational confusion created by the large number of poorly-conducted or conflicting research studies conducted each year.

Policy Recommendations

In the final analysis, our lack of knowledge about the clinical and economic effects of various drug coverage policies dwarfs our present understanding. However, enough is now known to warrant the following recommendations:

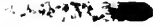
1. Given the panoply of drug coverage policies across the 50 states, and the known adverse effects of incomplete or piecemeal coverage, we recommend that a national minimum standard be established for drug coverage in vulnerable populations. These populations should include all current Medicaid eligibles, as well as other currently uncovered low-to-moderate income individuals who are elderly, disabled, or have major chronic illnesses such that their quality of life or independent functioning depends substantially on access to cost-effective medications.
2. Drug prescription claims forms and data bases should be standardized throughout the country, and linkable to other health services data bases. This would allow the development of educational and administrative interventions targeting measurable and important medication use problems.
3. Arbitrary caps on patient-level medication use (e.g., three-drug or dollar limits) should be disallowed in standard benefit packages. These payment restrictions have been proven to reduce access to essential medications, increase institutionalization, and raise costs.

4. Expanded coverage must be accompanied by cost-containment initiatives, which can reduce unnecessary utilization while maintaining essential care. This is clearly a difficult task. If patient cost-sharing is recommended as one lower-risk alternative to arbitrary payment caps, the co-payment amount should be set at the lowest possible levels for people with reduced incomes. The goal of such cost-sharing should be to act as a mild disincentive to over-use, but not as an economic barrier to necessary use.
5. Drug price inflation continues to be a serious concern for Congress, the Administration, health professionals and consumers. Although the causes of this problem are complex, and not our area of expertise, several strategies might be pursued:
 - After a medication loses its patent protection, expanded drug benefit programs could mandate reimbursement at the price of lower-cost generic equivalents.
 - As more citizens become covered in ever-larger prescription drug plans, government and private payors will have more bargaining power to negotiate lower prices as a condition of coverage of new and expensive agents.
 - Mandatory price controls are one option for reducing drug expenditure inflation; however, the industry would argue that such an action might threaten development of effective new drugs.
6. Inappropriate and inefficient prescribing by physicians is another significant cause of excess expenditures (see Attachment 3, which includes a review of studies attempting to address this problem). Several educational outreach methods described in this critical analysis of the literature have been shown to reduce inappropriate utilization of expensive or risky medications. These efforts--as well as the drug utilization review programs required by OBRA 1990--should be rigorously evaluated for their efficiency and effectiveness in large-scale applications.

We thank you in advance for considering these important issues, and look forward to hearing the outcomes of your deliberations. In addition, we would be glad to provide any additional information on the issues we have discussed at a later date.

Sincerely,

Stephen B. Soumerai, Sc.D
Director, Drug Policy Research Group
Associate Professor of Social Medicine



Dennis Ross-Degnan, Sc.D
Assistant Professor of Social Medicine

Thomas J. McLaughlin, Sc.D
Instructor in Social Medicine

SS:lg
enclosures

cc: Judy Feder, Ph.D, Dpt. of Health & Human Services
Jinnet Fowles, Ph.D, Park-Nicolette Medical Foundation
Health Care Reform Task Force

HEALTH CARE SERVICE DELIVERY INFRA- STRUCTURE IN INNER-CITY AND RURAL COMMUNITIES

THURSDAY, JUNE 24, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:07 a.m., in room 1310A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 1, 1993

PRESS RELEASE #15
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to health care service delivery in inner-city and rural communities. This hearing will be held on Thursday, June 10, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "Having a health insurance card is not enough to guarantee all Americans access to the health care services they need. Health care reform will not succeed if it ignores the need to improve the availability of services in our inner-city and rural communities."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Much of the health care reform debate involves a discussion of alternative ways to finance coverage of health care services for all Americans. Inner-city and rural communities, however, often lack the facilities and health care providers needed to guarantee access to services regardless of the extent of insurance coverage.

Over 18 million Americans live in urban areas suffering a shortage of primary care physicians. As a result, many inner-city residents depend on hospital emergency departments and outpatient clinics for primary care services. Hospitals and community health centers in these communities must also provide specialized services associated with health and social problems such as drug abuse, tuberculosis, AIDS, and teenage pregnancy.

According to the Office of Technology Assessment report on Health Care in Rural America, 111 counties in the United States had no physicians at all in 1988, and half a million rural residents live in counties with no physician trained to provide obstetric care. Even in relatively well-populated rural areas, the existence of few local providers and the lack of a public transportation system can make it difficult for many rural residents to reach facilities where they can receive care.

The Subcommittee requests that testimony focus on the problems facing health care delivery systems in underserved areas, ways of improving access to needed services for these vulnerable populations, and issues that need to be resolved for inner-city and rural areas under health care reform proposals that rely on providing access through competing health plans.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, June 24, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

*** NOTICE--CHANGE IN DATE AND LOCATION ***

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 8, 1993

PRESS RELEASE #15-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN DATE AND LOCATION FOR THE HEARING
ON
HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee hearing on health care service delivery infrastructure in inner-city and rural communities scheduled for Thursday, June 10, 1993, beginning at 10:00 a.m., in the main Committee hearing room 1100 Longworth House Office Building has been postponed until Thursday, June 24, 1993, and will be held in room 1310-A Longworth House Office Building.

All other details for the hearing remain the same. (See press release #15, dated June 1, 1993.)

Chairman STARK. If our guests could cease conversation and make themselves as comfortable as they possibly can, we would be glad to accommodate press or members in the first two chairs on the dais. That might free up a chair or two.

Today the subcommittee continues its series of hearings on health care reform with a discussion of health care services for inner-city and rural communities.

Much of the debate revolves around questions of how to organize and finance a system of universal health insurance coverage. Guaranteeing access to health insurance is a central issue, but it is not the only access issue that needs our attention.

Today we will discuss another critical dimension of the health care access problem: How do we ensure that health care services are available to people in inner-city and rural communities. Many of these communities do not currently have the facilities and health professionals sufficient to meet their health care needs.

More than 18 million people live in urban areas designated as primary medical health professional shortage areas. I might add parenthetically that within 10 blocks of this hearing room, we have a federally designated underserved area. Hospital emergency rooms and clinics often end up serving as the only available source of primary care for families in many inner-city communities.

And the capital needs of many of these safety net facilities have gone unmet for a long time, jeopardizing their ability to deliver quality care to large portions of our population. While the needs of rural areas have their own unique characteristics, one key element is common to both rural and inner-city—services are often not available where people need them.

Without a doctor in the community, rural hospitals are forced to close. As a result, residents of many rural areas must travel long distances or go without needed health care services.

We must keep the special problems of delivering health services to residents of the inner-city and rural communities in mind as we develop health care reform legislation.

The managed competition approach to health care reform under development by the administration could exacerbate the problems of underserved inner-city and rural areas. Because of special health care needs and social problems, health plans may not choose to compete to cover residents of inner-city areas. In sparsely populated rural areas, there is simply too little business to allow for development of competing provider networks or to attract competing health plans.

I look forward to exploring these issues with our witnesses today. Yesterday I was joined by several colleagues in introducing the Essential Health Facilities Investment Act, H.R. 2494, which is designed to improve the health care infrastructure in inner-city and rural areas.

The bill would create a Federal program of financial assistance for the capital needs of urban and rural safety net providers. Loan guarantees, interest subsidies, and emergency grants would be available to assist these facilities in upgrading their physical plant.

The bill would also extend the Essential Access Community Hospital program, EACH, of grants for the development of rural health networks to all 50 States. Further, it would establish a similar pro-

gram of essential community provider networks in urban areas, linking hospitals and community health centers in order to provide a full range of services to inner-city populations.

While I am aware that our witnesses have not had the opportunity to study the bill in detail, I would like to solicit their reaction. We are fortunate to have with us today a number of individuals who are working to provide health care services to residents of inner-city and rural areas.

This should offer the Members an opportunity to explore the best approaches for improving access to services in these areas.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I look forward to the testimony before us today because anyone who attempts to build a model for most of the United States, whether it is the administration in what they call a managed competition model or anyone else, will not be able to resolve the problems that we are going to address today because whether it is urban or rural, we are talking about underserved areas.

Our job is to figure out how we can deal with the unique problems of both inner-city and rural areas with a general understanding of the problems of the underserved. This may have to be an add-on component to any health reform model that attempts to provide a uniform solution for all of the United States.

I represent a predominantly rural area which has had some success with rural health care clinics to the point that they have expanded far beyond the targeted population that they had originally anticipated serving.

So, Mr. Chairman, I look forward to the testimony today to help us understand the particular common and unique problems of both the inner-city and rural areas so that as we go forward with the health care restructuring in the United States, we have an understanding of the problems of those who don't see themselves as provided for in any general health care reform being discussed.

Thank you, Mr. Chairman.

Chairman STARK. Are there other Members who have a statement? Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. I just don't want the opportunity to pass without welcoming our two colleagues, Mr. Slatery and Mr. Gunderson who I enjoyed serving with on the Rural Health Care Coalition and who have been players in this debate, although not members of this committee.

I note, and I, like the witnesses, have not read your legislation that you introduced yesterday, but based on the way you described it, it sounds as though it contains concepts that have been advanced by the Rural Health Care Coalition, particularly the Essential Access Community Hospital program. The EACH and RPDH programs are a concept that track right along with a Republican initiative that is now making its way back through Congress and hopefully will be an area of common ground.

It is important when we talk about access to remind people that do not know that in rural areas, access and insurance are not the same thing. Particularly in the State of Iowa, which is the third most heavily insured State in the United States. Our problem is not insurance, it is doctors, hospitals, and getting people to them.

I might say finally, the whole access problem relates to a crumbling infrastructure which has been penalized, unfortunately, through the Medicare reimbursement system. I am sure our colleagues will elaborate on this, but unfortunately one of the ongoing fights we have had in this committee is to find better ways to reimburse the parapractitioners of medicine, the physician assistants, the nurse practitioners, who very often become the key components of a rural health care infrastructure in the absence of major health care facilities.

So I look forward to hearing these two gentlemen today and I hope that this will be the beginning of an ongoing discussion between Republicans and Democrats in the House to at least realize that there are essential access decisions that we can make prior to any major change in our health care system that I hope at least this subcommittee will take the lead in making these changes.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I too want to thank you for holding these hearings.

This is a very important subject as to how health care reform can be structured in order to make sure that we have access to quality health care for all the citizens of our country.

As we look to use market forces to help control health care costs, we run into a real risk with inner-city care, rural care, specialty care units, or teaching facilities as to how they will be able to compete with facilities located in less costly areas.

I hope this hearing will help us focus in on this very difficult component of health care reform. As I have sat on this committee, I have seen well-intended changes in our laws that have been aimed at trying to deal with this problem that have not been successful. As we look for changes and modifications of the health care system, I hope it works, but I am concerned as to whether any national type of an add-on or modification will fit the problems of all the different areas of our country.

I would like to call to the committee's attention the method of allowing the local governments to set up their own rate setting and to take these factors into consideration. My State of Maryland has an all-payer rate system for hospital care that is sensitive to the special concerns of rural hospital care and inner-city hospital care and teaching facilities and specialty care units, and I would hope that as we review the different options that are available, that we focus in on giving more flexibility for local rate setting, particularly the all-payer rate setting, to deal with these problems rather than trying to solve all these problems through one national model.

Chairman STARK. If there are no further opening statements, I would like to welcome our first witnesses this morning, our colleagues, Jim Slattery of Kansas and Steve Gunderson of Wisconsin, my natal State. They are appearing jointly in their capacity as cochairs of the Rural Health Care Coalition Task Force on Health Care Reform of which I am an adjunct member due to a vacant lot in east Oakland which qualifies me as having a rather large rural area.

The coalition has been very active over the years in pursuing policies to improve health services in the rural areas. We are fortu-

nate to have the benefit of your expertise on these issues, and look forward to your testimony.

If you have a written statement, it will appear in the record in its entirety and if you would like to enlighten us, expand on any statements, proceed in whichever order you have agreed.

STATEMENT OF HON. JIM SLATTERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS, COCHAIR, HOUSE RURAL HEALTH CARE COALITION TASK FORCE ON HEALTH CARE REFORM

Mr. SLATTERY. Well, thank you, Mr. Chairman, and it is a pleasure to be with you today and the members of the committee. I appreciate your interest in this topic that we are going to address too, and first let me observe, Mr. Chairman, that if you would like to be an honorary member of our coalition, let me just say that ownership of that vacant lot or residence on that vacant lot would qualify you. In either case, we welcome you, Mr. Chairman.

As you know, we represent the Rural Health Care Coalition. Some 146 Members of the House are members of this coalition. We have joined and come together in an attempt to make sure that the unique concerns of rural America are not ignored as we shape health care policy in our Nation's capital.

Let me observe that many of the problems that we experience in rural America are also experienced in underserved urban areas of this country, and as the Chairman knows, and as members of this committee know, the biggest problem that we have is perhaps poverty, and the fact that the poverty rate in rural America today is very high.

In fact, nearly 30 percent of the people in rural America are living with incomes below the poverty line. So that is one thing that they certainly have in common with their underserved counterparts who live in the inner cities of this country.

As we deal with the question of national health care policy as it affects these underserved rural areas, I want to focus on several things today. And my friend, Steve Gunderson, who is cochairing the Task Force on Health Care Reform for the coalition will offer additional comments, but the one thing that I wanted to focus on was the need for us to provide the incentives to build up networks and infrastructure in our rural areas, and I am very pleased with the action that you have taken yesterday in the introduction of I guess a reauthorization bill for the EACH program and I think you are right on target.

I haven't had an opportunity to review the details of your legislation but certainly you have played a constructive role in the past in trying to nurture and encourage the establishment of the kind of networks that our coalition strongly believes will have to be a central part of the reform as it is implemented in rural America.

So that is good news to this Member and I am sure good news to the members of our coalition.

The EACH program and the RPCH program that probably members of this committee are familiar with is a model that has worked, I think, very well in the past and it is one that we should build on, and I have joined with other members of the Rural

Health Care Coalition in introducing EACH amendments of 1993, H.R. 1768, which this committee will probably take a look at.

Basically this approach is merely to reauthorize the EACH program and provide the States with more flexibility in trying to shape the networks that we believe are very, very important. So I think we are on the same track when we talk about the EACH program and the RPCH program and the need for it to be integrated into the kind of reform that we move toward.

In addition to that, something that the coalition feels very strongly about also is the need for us to enact antitrust legislation to remove some of the barriers that hospitals, especially in rural communities, are confronting when they attempt to enter into joint ventures that will hopefully avoid duplication of services.

I represent communities, for example, that have several hospitals. The largest community in my district is about 140,000 and we have two hospitals operating literally right across the street from each other and they are world class facilities; I have other communities with a population of less than 60,000 that also have two hospitals and when I sit down and visit with the boards of directors of those hospitals and talk to them about the need to enter into joint ventures to avoid duplicating services and buying unnecessary capital investments in their community, oftentimes the first thing that they raise to me is the fact that they are concerned about being sued for violating the antitrust laws in the event that they even sat down and talked to their counterpart across the street.

As far as I am concerned, this is just an absurdity in the law that needs to be addressed and I think members of the coalition share that concern. So I would hope that members of this committee, to the extent that you might have some jurisdiction in this area, will be supportive of our attempt to eliminate this antitrust barrier that we believe bars us from entering into the kind of joint ventures that will hopefully save the taxpayers and the consumers a lot of money with a more efficient utilization of our health care dollars.

Another thing I will touch on is the need for us to do everything we can to encourage the development of really world class state of the art interactive voice video telecommunications capability that we feel holds the promise of enormous potential to improve the quality of the health care delivery system in rural areas, and there are some very unique models already being developed across the country, one in Kansas, that is an exciting model that I think is worthy of consideration.

Chairman STARK. Did you see the one that they had at the demonstration here a month or so ago in the Rayburn Building?

Mr. SLATTERY. Yes, and there are some exciting examples of what can be done with the utilization of interactive voice video capability across the country, and I just want the committee to be aware of that and be supportive of doing everything we can to encourage that sort of new innovation.

The last thing that I will focus on is something that our friend from Maryland has already touched on and I am delighted to hear him comment on this. That is the need for us to encourage States

and local participation in the delivery of health care in this country.

As far as I am concerned, and this coalition believes very strongly that States ought to be given the opportunity to achieve whatever Federal cost, quality, and access requirements are agreed upon. The States should be empowered to achieve those objectives within broad areas of flexibility, and I happen to believe very strongly that the States need that flexibility for the reasons that Ben Cardin has already outlined and I hope that whatever we do in this area recognizes that.

The last thing I will touch on before yielding to my friend from Wisconsin is that if we move toward some kind of State budgeting process, it is extremely important that we not rely on historic spending patterns to determine what these State budgets are going to be, because in our judgment, the historic spending patterns have been historically very inequitable, especially when one examines the reimbursement formula under Medicare, for example.

So I think it is very important, if we do move in that direction, which I have some very serious concerns about, but if we do move in that direction, it is very important that that be done in such a way as not to build in another major disparity in the budgeting process for the health care delivery system in this country.

So with that, Mr. Chairman, again, I express my appreciation to you and the members of this committee for your interest in this. I look forward to working with you from my rollover on the Energy and Commerce Committee and we have a lot of work ahead of us, needless to say, and it is a pleasure to be with my colleague from Wisconsin today and I will yield to him at this time.

Mr. GUNDERSON. Well, thank you.

[The prepared statement follows:]

STATEMENT OF THE HONORABLE JIM SLATTERY (2ND-KS)
BEFORE THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

HEARING ON
THE HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES

JUNE 24, 1993
10 A.M.
1310A LONGWORTH

Mr. Chairman, I'd like to thank you for holding this hearing and for allowing me and my colleague, Rep. Steve Gunderson of Wisconsin, to participate today. As you know, Rep. Gunderson and I are here on behalf of the House Rural Health Care Coalition (Coalition) which is a bipartisan group of 146 Members representing diverse interests, but each one concerned about access to quality health care in rural America.

As co-chairs of the Coalition's Task Force on Health Care Reform we are interested in presenting the Coalition's priorities in this area.

One of the measures of success of the health reform package developed by the Clinton Administration will be how it addresses the unique needs of the approximately one-fourth of the U.S. population that live in rural areas of our country.

We believe that health care reform will not succeed if it ignores the need to improve the availability of services in our inner-city and rural communities. Rural communities, in particular, often lack the facilities and health care providers needed to guarantee access to services regardless of the extent of insurance coverage.

This morning I will briefly provide you with a rural health profile and highlight the Coalition's priorities for health care reform regarding the development of integrated delivery systems and also the role of the states in the area of reform. Rep. Gunderson will conclude by highlighting the Coalition's priorities concerning provider shortages and access to emergency services.

RURAL HEALTH PROFILE

The statistics regarding risks and rural health care are daunting. Rural areas have a higher share of risk than urban and suburban areas. More elderly and more people in poverty live in rural areas than urban or suburban ones.

With the exception of inner cities, rural areas hold the largest percentage of people living in poverty. While rural areas account for 25 percent of the U.S. population, 30 percent of rural residents live below the federally defined poverty level.

Poverty has a direct and adverse impact on health status. People in rural areas generally have more chronic care needs than urban or suburban centers, such as arthritis, heart disease, vision and hearing loss, and emphysema.

Furthermore, not only are rural areas poor, they are dangerous. Agriculture has bypassed mining as the nation's most dangerous occupation. Nearly 15 percent of all work-related deaths are in agriculture, even though agricultural workers represent less than 3 percent of the American workforce.

Added to the health-related risks of rural populations, is the heavy provider reliance on government programs. What little health care coverage rural citizens have is often paid for by Medicaid and Medicare. Consequently, rural hospitals and providers can depend on the government for as much as 40 percent to 60 percent of their revenues. While urban and suburban providers can shift costs to privately insured patients to compensate for the lower fees paid by Medicaid and Medicare, privately insured patients are simply lacking in rural communities.

Given this profile of risk, age and disability, rural Americans are not a group most companies would rush to insure. However, even assuming that a health care reform package will require universal coverage, this is no guarantee that access to care will be provided.

INTEGRATED DELIVERY SYSTEMS

-Provide Incentives to Build Up Infrastructures

We must encourage and develop integrated health delivery systems. Health care reform must create incentives for hospitals, physicians and other providers to participate in community-based systems of care and networks. It will be necessary to facilitate the establishment of networks and new health plans in rural areas.

The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program serves as a good model of the direction we should be heading in health care reform. The Chairman's leadership in creating this program is greatly appreciated. The EACH program allows for the development of rural health networks by providing incentives to hospitals and communities to cooperate and contain costs.

I introduced the EACH amendments of 1993, H.R. 1768, to make this program better and give states the authority to allow for a little more flexibility in creating their networks, making them more responsive to the needs of the communities involved.

The Coalition and I hope that this committee will continue to support this program and initiatives which promote cooperation and collaboration in order to maximize efficiency and reduce duplication of services. Restructuring health care delivery in rural areas must be a top priority in health care reform.

-Remove Antitrust Barriers

A problem which continues to obstruct progress in the area of cooperation among health care providers is antitrust enforcement. The Coalition continues to hear from hospitals and providers that the threat of actions by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) has had a chilling effect on consolidations and agreements of service which many view as essential tools for financial survival and the only option for maintaining access to basic health care services to rural and underserved areas.

Earlier this year I introduced the Hospital Antitrust Fairness Act, H.R. 1765, which is supported by the Coalition. H.R. 1765 provides relief to hospitals attempting to merge, consolidate or contract on agreement of services by revising the standard of review utilized by the FTC and the DOJ.

The Coalition strongly believes that health care reform must address antitrust concerns through education and legislation to reduce liability and allow for constructive cooperation among facilities and providers. If integrated health care delivery systems are going to get the chance they need to be created and to be successful, this area of policy will require some change.

-Develop and Expand Telecommunications Systems

Hospital closings and the lack of trained staff create hardships for Americans who require quality health care in underserved areas. Medical facilities can use remote two-way, interactive video consultations to provide patients with access to medical experts and specialty services not available at their facilities, especially in rural and remote areas.

The Coalition supports the development of telecommunications systems and networks, where cost effective, in order to provide greater access to education for rural practitioners and immediate consultation with specialists which can provide life saving care and save travel time.

The primary savings from remote consultation comes from reducing overhead costs and travel time for rotating specialists. More substantial savings may be expected from reduced inappropriate treatment. Other benefits include increased patient convenience due to reduced travel time to see a specialist, and the ability to more easily obtain a rapid second opinion which currently can take several days.

Through telecommunication system development "distance learning" can be pursued allowing health care employees to keep abreast of new technologies, practices, and skills. Claims management and processing can also save time and money if effectively included in telecommunication networks serving rural areas.

Telecommunications technology and applications offer positive solutions for the national health care crisis.

ENCOURAGE STATE AND LOCAL PARTICIPATION

Each state has unique characteristics; one federal model for health care reform may not fit every state's needs. Health care reform must encourage state and local participation.

The Coalition believes that states ought to be given the opportunity to achieve federal cost, quality and access requirements through alternative approaches if it can do so.

Should establishing state budgets for health care costs be included in a reform initiative, we can no longer allow for those budgets to be based on historical spending patterns which have been historically inequitable.

Finally, assuring rural representation on decision making bodies will also be critically important.

Mr. Chairman, thank you for letting me participate today, now I'd like to let Rep. Gunderson follow up on some other priorities the Coalition has for health care reform. I look forward to working with you as we move a health care bill through this Congress.

Chairman STARK. Steve.

STATEMENT OF HON. STEVE GUNDERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN, COCHAIR, RURAL HEALTH CARE COALITION TASK FORCE ON HEALTH CARE REFORM

Mr. GUNDERSON. Thank you, Jim and Mr. Chairman. It is a pleasure and honor for me to be here before your committee.

I can tell you that Wisconsin is indeed proud of you, its native son, as legislating health care this year but I have to also tell you that we are counting on you and Mr. Kleczka to make sure all Wisconsin's concerns are solved, as well as with the dubious honor goes the dubious responsibility too.

But your opening comments were absolutely accurate. We have a problem in the rural areas and in the inner cities where we simply don't have the health care professionals when we need them and I would like to concentrate my remarks this morning on this whole issue of providing access to emergency services and the importance of alleviating health professional shortages in our rural communities.

Rural citizens, even more than the average U.S. citizen, face additional challenges in the area of emergency care, because rural citizens tend to have more serious injuries and emergency medical care is often more difficult to deliver in those rural areas.

I would like to suggest to you as you consider this basic premise and as we all struggle with the question do we keep rural hospitals open, what do we do in rural communities, what don't we do, I think the basic underlying premise that works for me is that we cannot guarantee immediate access to basic health care throughout rural America, and I don't think that is the Federal Government's responsibility.

However, I do believe it is essential that we design a system allowing rural areas to guarantee access to emergency lifesaving health care. Big difference. It is imperative that any health care reform package that passes the Congress include provisions assuring access to this comprehensive 24-hour emergency care.

Both you, Mr. Chairman, and Mr. Slattery have talked that we might be able to take a step in this direction in terms of quality emergency care by creating a telecommunications program which we have included in our emergency medical services amendments of 1993 initiative, which I introduced.

I give you a real life example of this. I have a small community hospital in my area. Those of you from Wisconsin are familiar with the concept of whey and whey pond. This is the fluid that is left over from the production of cheese. Last year we had a whey pond outside the cheese plant and a young kid was playing on it in the spring of the year and he fell into the pond. When he was rescued, he was taken to the local emergency room. Yes, indeed, they provided the best care they could.

They got on the phone with a quality emergency hospital in an urban area because they had never before had a case like this. It wasn't only a traditional drowning or falling through a pond, but it is a kid, his lungs were absolutely full of this whey product and they didn't know how to respond.

Well, they had the telephone, but boy could they have used the telecommunication so that that expert on the other end could have seen the patient and vice versa. Tragically in this case we were not successful in saving that young person's life.

Another solution to ensuring that rural Americans have access to emergency medical care would be the creation of comprehensive emergency medical centers in rural areas. Representative Craig Thomas of Wyoming and I are currently drafting such a proposal. Under our legislation, the Secretary of the Department of Health and Human Services could waive the Federal Medicare conditions of participation to establish a new limited service category for financially insolvent, sole community hospitals in danger of closing due to low inpatient utilization rates and negative operating losses.

Conversion would only be allowed if the Secretary finds, number one, access to critical services would be severely limited to residents if the hospital closed; two, if there is a written affiliation with a nearby full service hospital to coordinate patient referrals; three, a physician is available by telephone and resides within 15 minutes of the facility; and, four, a midlevel practitioner is on site 24 hours.

I can tell you, Mr. Chairman, again, on a personal experience, my hometown hospital with 8 percent inpatient utilization today is literally this year being subsidized by the local city council. They are awaiting the action of Congress this year to see if we can design some kind of flexibility that would allow them to change their mission, keep that emergency care, which is essential, so that they can continue, and while we haven't had time to study your bill from yesterday in depth, we would love to work with your staff on that, each proposal as it might relate to emergency care. I would make that offer.

The final area, Mr. Chairman, that I have been asked to address is this whole area of health professional shortages. As you know, there are 2,000 such areas in the United States. Half of these are in rural areas. Urban counties have more than twice as many practicing physicians per 100,000 residents as rural counties.

We all know part of that is due to the specialists we all use, et cetera, but it does help alleviate or indicate, I think, the distinct rural problem in this area. The Rural Health Coalition—the House Rural Health Coalition, supports several initiatives that would help alleviate provider shortages.

They include establishing equitable reimbursement policies as Mr. Slattery mentioned, restructuring the incentives in graduate medical education, to promote the education of primary care practitioners. I think we all agree that is likely to happen, two, expand the National Health Service Corps program so a range of providers will be placed and given incentives to remain in underserved areas and number four, encourage the enhanced utilization of midlevel practitioners in many areas WIC meet the nonemergency need.

That, Mr. Chairman, concludes my summary of my written statement. I am delighted with the opportunity and look forward to working with you.

Chairman STARK. Well, I want to thank both of you.

[The prepared statement follows:]

REP. STEVE GUNDERSON'S TESTIMONY

SUBCOMMITTEE ON HEALTH

HOUSE WAYS AND MEANS COMMITTEE

JUNE 24, 1993

Mr. Chairman, thank you for the opportunity to testify before your subcommittee. As Representative Slattery said in his introductory remarks he and I serve as the co-chairs of the House Rural Health Coalition's Task Force on Health Care Reform. Mr. Slattery focused on the coalition's views regarding the integration of delivery systems and the importance of encouraging state and local participation in implementing health care reform. I would like to concentrate my remarks on providing access to emergency services and the importance of alleviating health professional shortages in rural communities.

The average U.S. citizen will need emergency care at least twice in a lifetime. Comprehensive emergency medical service systems are essential to our health care delivery system. Rural populations face an additional challenge because rural citizens tend to have more serious injuries and emergency medical care is often more difficult to deliver in rural areas. The Office of Technology Assessment's Report on Rural Emergency Medical Services stated that persons involved in rural accidents are three times more likely to sustain serious or untreatable injuries than those in urban areas.

We cannot guarantee immediate access to basic health care throughout rural America. However, we must design a system allowing rural areas to guarantee access to emergency life-saving

health care.

It is imperative that any health care reform package that passes the Congress include provisions assuring access to comprehensive 24 hour emergency medical care. This could be achieved by creating a telecommunications program which I have included as a provision of my Emergency Medical Services Amendments initiative of 1993. A telecommunications program will enable patients and health professionals in rural communities to link-up with medical specialists in larger health facilities for consultations regarding life-saving treatment. This activity will be accomplished by rural facilities using telecommunications such as static video imaging transmitted through telephones and facsimiles. The development of this project will enable rural hospitals to stabilize and treat patients in critical conditions who are unable to travel long distances to comprehensive medical centers.

Another solution to ensuring that rural Americans have access to emergency medical care would be the creation of comprehensive emergency medical centers in rural areas. Rep. Craig Thomas (R-Wyoming) and I are currently drafting such a proposal. Under our legislation, the Secretary of the Department of Health and Human Services would waive the federal Medicare conditions of participation to establish a new "limited service category" for financially insolvent sole community hospitals in danger of closing due to low inpatient utilization rates and negative operating losses. Conversion would only be allowed if the Secretary finds: 1) access to critical services would be

severely limited to residents in the community if the sole community hospital were to close or closes; 2) there is a written affiliation with a nearby full service hospital to coordinate patient referrals and other service needs; 3) a physician is available by telephone and resides within 15 minutes of the facility; and 4) a mid-level practitioner is on site 24 hours. The following example illustrates the necessity of this legislation. A small rural hospital may have difficulty in maintaining inpatient care. However, that facility has a large emergency patient load and should remain open despite the loss of inpatient care. However, under current law, the entity would not be able to administer emergency care because it cannot be classified as a hospital when inpatient service is no longer a component of its delivery system. Thus, an entire community will be without emergency medical care.

There are approximately 2,000 health professional shortage areas in the United States. Over half of these designations are located in rural areas. Urban counties have more than twice as many practicing physicians per 100,000 residents than rural counties. The House Rural Health Coalition supports several initiatives that would help alleviate health provider shortages. These include: 1) Establishment of equitable reimbursement policies for all providers. Such policies must not perpetuate historically inequitable spending patterns; 2) Restructure the incentives in graduate medical education financing to promote the education of primary care practitioners; 3) Expand the National Health Service Corps program so that a range of providers will be

placed and given incentives to remain in rural and underserved areas; 4) Encourage the enhanced utilization of mid-level practitioners (i.e. physician assistants, nurse practitioners, and certified nurse midwives).

I thank you for the opportunity to testify and look forward to working with you to ensure that a comprehensive health care plan will guarantee accessible and affordable health care to all rural Americans.

Chairman STARK. I am in agreement with your suggestions and your concerns. We have a problem in just how the world perceives what we are going to do. Neither of you are old enough to have gone through the consolidation of K through 12 schools in the community high schools and getting rid of six-man football teams and—

Mr. SLATTERY. I actually did live through that.

Mr. GUNDERSON. I hate to indicate my age, but I went to a two-room country school and my mom was on the school board when we consolidated.

Chairman STARK. The fight is going to be in your districts. Every city wants to have a consolidated hospital and what do you say to the cities that get the heliport or the emergency room and the clinic?

And a 25-bed hospital in general is not able to survive financially and provide the kind of care that is needed in an increasingly complex medical center and we are going to have to figure out how to help you get your communities to accept whatever we can do to change that.

The second issue is we are going to have to get the medical care providers in some rural areas to begin to think, as they have in some of the more urban areas, that working for an organization for a salary is not unethical, so that we can let States if they choose to actually run clinics, hire doctors, give them some support if they choose to do that or let the national health service provide those areas, both in rural and inner city, and those are some considered not quality jobs, or it is second-rate medicine. We have got to change that thinking.

The only thing that I made in the EACH, RPCH submission is that we included inner-city trauma centers. In other words, we based this on the need, as you suggested, Steve, first and foremost of being able to provide emergency reaction in any area, rural or urban.

Quite frankly we finance it by charging the other hospitals who are better financed something on their payments and redistribute it to see that these areas are served.

It does deal with the antitrust. As nearly as we have jurisdiction, and this is a subject for Chairman Brooks' review, but what we would say is when a project is approved by the State, it would receive what we have termed State action immunity. That is a term from antitrust action, but the hospitals that have to have those projects approved by the State under some kind of a capital allocation plan, so we have made an attempt, where the States want to support some kind of merger or joint venture, to see if we can get immunity.

Whether that will hold or not, I don't know. I did see the video demonstration of an operation inside a person. I could not watch the whole thing, I suggest, but it is just amazing virtually seeing an x ray described over the television while you watch the radiologist as if they were talking to the doctor pointing to the parts of body and describing what the x ray did, and I gather that this kind of technology is becoming broadly available.

We have got to be able to encourage that kind of change, and I appreciate the fact that I think we have a coalition. We have had

hearings in this room dealing with Wards 7 and 8 of the District of Columbia where basically there is a real shortage of medical service to people whose access isn't hundreds of miles. It is three transfers on the Metro when you have to dress three kids to take them on a service with a transfer to get from Ward 7 and 8 perhaps to Ward 1 or 2.

Traveling over a hill or through a snow-clogged pass also can be a real deterrent to getting to needed medical care. So we hope to be able to work with you to make some real progress in this area.

Mrs. Johnson.

Mrs. JOHNSON. No questions.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Let me thank both our colleagues for the testimony. Jim, I agree with the point that you made about allocations to the various States as far as the historical expenditures versus what would be reasonable expenditures with the demographics.

It is an issue that is going to be difficult for us to deal with on health care reform.

Steve, I appreciate the fact that for emergency care we need to make special arrangements for access so that every American has reasonable access for emergency care. But I am just wondering as to your views on whether a competitive model works for rural America.

The need for primary care physicians, the need for other facilities to be located in rural America in order to have adequate health care for people who live in the rural areas, can a model can be structured in the way that would be fair for the people who live in rural areas?

Mr. GUNDERSON. I think the jury is out on that, no question about that, and obviously you have listened more than I have at this table to the medical scholars on both sides of that issue. I will tell you what is happening in the upper Midwest.

We are seeing the development of regional medical centers, Mayo Clinic is doing a dramatic expansion. We are seeing our medium-sized hospitals doing dramatic expansion into those smaller communities with clinics and taking over those rural hospitals, et cetera, so whereas if we were talking the true sense of competition between one doctor and the next in that small town, obviously you can't have managed competition in that sense because we don't have the competition there.

But if you are talking on the bigger scale of can a Gunderson Clinic or a St. Francis Hospital or a Mayo Clinic or a Marshfield Hospital in the upper Midwest, can they compete in regional delivery systems? I think the answer is yet to be determined on that. They are certainly preparing for what they anticipate is going to come.

Mr. CARDIN. The problem is that, as you point out, you could always come into a suburban hospital for your care, if it is not emergency care, yet to have a comprehensive hospital located in rural areas, it is important for access to health care in that community.

And the question is if you have the most efficient rural comprehensive hospital, can it compete with a suburban hospital in a less costly environment?

Mr. GUNDERSON. No, it can't, and I think we have found out some other major dynamic that has occurred. I remember as a young kid going to the dedication of the Osseo Community Hospital in the early 1960s, what a big day it was for our community.

But I have got to tell you today, those same people that built that hospital 30 years ago have no problem driving 30 miles to Eau Claire to the malls to buy their clothes. Now, if you are going to go to that mall to buy your clothes, I guarantee you are going to go to that city for specialized health care. So we have got this problem.

We are keeping our hospital open because the city council is continuing to subsidize it awaiting Federal decisions on what we are going to do or not going to do and I have come to the conclusion as a rural Congressman, I am not going to take the position that I am supporting keeping every rural hospital open or, on the other side, that I am going to support closing some of them. That is going to be that local community's decision.

What I think we do have a responsibility to do here however is to guarantee that every citizen in this country, no matter where they live, in Washington, D.C., or rural Wisconsin, has access to lifesaving emergency care. We will then let that rural community make the other decisions on basic and specialized health care for themselves.

If they want to subsidize it to keep it open, their decision. Their money, they can do it. If they don't, that is OK, too. They will have made that decision, not us.

Mr. SLATTERY. If I could make a stab at this too, Ben, one of the things I have observed, as you know, there are rural hospitals all across this country closing right now, rural communities are making these decisions.

I have a hospital in my district that is making this decision in the next few weeks. I think that when you look at the whole question though of managed competition, it is going to work in rural America, we have to look more specifically at what part of rural America.

For example, I represent 23 counties in eastern Kansas that extends from the Nebraska border south to the Oklahoma border basically around Kansas City. In my area, I think managed competition can be structured around those major cities that I represent and around Kansas City, which I don't represent, in such a way as to really deliver quality health care services to the residents of my district. It could be done.

However, in western Kansas, in an area that Pat Roberts represents, for example, where there are almost 50 rural counties and maybe the largest city in his district is 50,000 or 60,000 the situation is entirely different, and we are going to need in our State clearly the flexibility to deal with the problems that we have in eastern Kansas in structuring a delivery system that will work there and have the flexibility to also structure a delivery system that works in western Kansas, and it is an entirely different environment in terms of delivering health care.

Western Kansas, the problem is a simple one, it is also a problem in eastern Kansas, and that is finding the providers to serve Good-

land and Dodge City and Hays and all the other small towns in western Kansas.

The problem is getting the providers there, and that is where I think that the National Health Service Corps, for example, is ultimately going to have to play a very big role in encouraging providers to serve those areas.

Mr. CARDIN. Thank you.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

I want to go back to something that Mr. Gunderson alluded to because I think without saying so he kind of touched on the dirty, dark side of the Hill-Burton Act which was to put hospitals in every community and watch as they lovingly went broke, because we have overbuilt our infrastructure.

But now you have communities that are reluctant to give them up because although in my part of the world they are not only the only source of health care in the county, they are usually the largest employer. But the fact of the matter is under any enlightened model, not all of these facilities can and should exist. Most of them now are becoming swing bed facilities.

I literally had a hospital in one of my small counties that was a 12-bed hospital. They had a hospital but they had no doctor. So they provided day care for the most part. But I also have in front of me right now an article that I guess is in today's Wall Street Journal and the headline is self-explanatory, "Dead On Arrival, the Clinton Health Plan."

Now, that may not be the case. It may not be DOA, but I think we are a long way from coming to any kind of closure on a massive managed competition superstructure for the United States, and I would like to ask you gentlemen, in lieu of major comprehensive reform, what can we do right now in the interim to at least move forward on the front that you folks are advancing and perhaps also address some of our intermediate and more pressing health care concerns which do relate to infrastructure and access?

So I would like you both to answer what we could do right now in the absence of a major Federal initiative to either enable States to move forward or to provide some Federal oversight in those areas, knowing that perhaps comprehensive reform may be a year or two away.

Mr. GUNDERSON. Let me offer a brief comment on that and I think we all run the risk that we all talk to all the health care policy professionals and we forget to talk to the real people.

I will tell you, the real people in this country are expecting and are going to demand some kind of response from this government very soon on health care. Their patience is running a lot thinner than I think all of us anticipate.

One of the things we have got to do this year is we have got to find a way to allow those hospitals that Craig Thomas has, that Jim Slattery has, that you have, that I have, we have to give them the empowerment to make that decision that if they are not going to be an inpatient hospital, that they still can get reimbursement if they have around-the-clock emergency rooms and care.

That is not allowed today under the Medicare provisions. We have got to change that this year to allow those communities to chart their own destiny.

Mr. GRANDY. I might point out and I agree with that concept, a couple of days ago, Mike Andrews hosted a meeting with a lot of the major Texas medical center folks who were based in Houston, one of whom is Dr. Red Duke, who is a premiere authority on trauma centers. His concept is for a national regional emergency network in this United States.

Do you think that is something that we should move forward with first? In other words, to kind of make sure that we can guarantee that kind of essential access before we worry about what the management model will be or what the insurance mechanism should be?

Mr. GUNDERSON. If you would look at the legislation I introduced last year, the Emergency Medical Services Act, we created the Office of Emergency Medical Service, the HHS. We allow them to work with the States to have each State develop their own State emergency medical services delivery structure.

I think as States begin to do that, the regional concept that he is talking about is going to happen. That is going to fit within the State flexibility that I think everybody on both sides of the aisle is talking about in some kind of health care reform, and more and more I think what we have tried to lay out in that legislation, and I will offer it again to this committee for its consideration, fits into that model and solves the problem.

Mr. GRANDY. And you would do that now in lieu of some kind of omnibus solution to our health care problems?

Mr. GUNDERSON. I don't think we can wait. Otherwise we have to find a way to subsidize all of these rural hospitals, that frankly cannot and perhaps should not exist.

Mr. GRANDY. What do you think, Jim?

Mr. SLATTERY. I totally agree. I will also say that I don't see any inconsistency with this committee and our committee and the Energy and Commerce moving forward with some ideas that will alleviate problems pending the ultimate solution, or there is not going to be an ultimate solution, let's be candid with each other.

We are just going to learn how to manage this whole problem a little better hopefully. But pending the enactment of a major reform package, we should be moving forward on different fronts with some other initiatives that will help alleviate the problem for goodness sakes, and hopefully what we do with an incremental change you might say is consistent with the long-term objectives, but I don't want to hold all of these good ideas that we may have hostage to the passage of some kind of a major reform package that may not occur for another year, if we are optimistic.

Mr. GRANDY. I support that and I hope that one of the roles that we might be able to play as a committee, and maybe brokers between what the White House wants to do and those of us who have individual ideas of how health care reform should be structured want to do, is to move some kind of fast track interim model so we can make some of these changes, because it is not enough to just say, we are standing still on health care.

Both of you know that, particularly in rural areas, a Medicare freeze could set some of these rural hospitals back, could really disadvantage not the hospitals but the beneficiaries, the people who are receiving those services. You couple that with a lack of tax deductibility for the self-employed and you are eroding the infrastructure.

So I am an advocate of that and I hope no matter what the White House comes up with, we can move on something hopefully this year.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Steve, in your testimony, one of the recommendations is to expand the National Health Service Corps, which I think you are a coauthor of and a supporter of naturally.

Is there any provision now for this type of inclusion or for this type of a program?

Mr. GUNDERSON. Is there any provision for expanded health service?

Mr. KLECZKA. Right.

Mr. GUNDERSON. In our legislation?

Mr. KLECZKA. Right.

Mr. GUNDERSON. From the rural health care caucus, yes.

Mr. KLECZKA. This would be in a committee bill that they are working on?

Mr. GUNDERSON. What committee bill?

Mr. KLECZKA. The Health Service Corps. This is your own legislation you are talking about?

Mr. GUNDERSON. What I gave in that area, Jerry, was the recommendations of the Rural Health Care Coalition, and do we know exactly who the main author of the Health Service Corps legislation is? We will get that to you. We will get that to you.

Mr. KLECZKA. All right. And the other question I had is, for years—and you served in the legislature along with myself—we had a program for family health centers throughout the State, Senator Chilson's proposal. Is that still an ongoing thing in the rural parts of the State?

Mr. GUNDERSON. You know I listened to people talk about community health centers and obviously Mr. Thomas and Mrs. Johnson are both strong advocates and can relate to the issue of community health centers. I don't know why community health centers work so well on the east and west coast and they don't seem to be as popular in the upper Midwest. I can't explain the dynamics.

Mr. KLECZKA. We were on the course of establishing family practice centers throughout the State and there was a lot of State participation.

Mr. GUNDERSON. I think it perhaps is that our whole health care delivery system in the Midwest was perhaps driven by Hill-Burton where we recreated a small town hospital, created a clinic across the street from it, and we brought in two or three doctors who would work at the clinic in the afternoons and they would do their rounds at the hospital in the morning and we designed a different delivery system.

That is all I can explain, because we just don't have a preponderance of community health centers in the Midwest, and I would—

Mr. SLATTERY. I would add to that that the reason we don't is very simple; that is, you do have the local community hospital there doing the kind of services arguably in a very inefficient way in some cases that the community health centers may be providing in other parts of the country.

But Hill-Burton succeeded to the extent that it encouraged the construction of an awful lot of hospitals out in the country, as you know, and those hospitals have been provided the services that the community health centers have provided in other parts of the country.

Mr. KLECZKA. Thank very much.

Mrs. JOHNSON. Would the gentleman yield for a moment?

Mr. KLECZKA. I will yield.

Mrs. JOHNSON. I want to see if I could ask you to look with me at what has happened in New Mexico where they seem to have gone a step beyond the Mayo Clinic and actually created some competition in the small towns as part of larger networks of care, and I don't think the rural caucus has looked at that, but it is the one model that I am aware of that I think has created some success in linking that might give us some useful indicators as to what else we might do now.

Mr. SLATTERY. I would just respond that in some parts of rural America, I am convinced that if you moved toward a managed competition type of model, that it is very conceivable that some of the larger neighboring community hospitals, and, for example, in the Kansas City area, they may decide to put some kind of a clinic out in a neighboring smaller town and that neighboring clinic may be in direct competition with the local community hospital in the provision of primary care, for example, and you could get into this kind of a situation where those clinics that were somehow part of a network of a large hospital in an adjoining urban area were able to deliver those services more efficiently in the community than the existing facility. That is conceivable.

It would probably create some other problems in terms of the overall viability of the hospital there too. So I mean that is the flip side of this.

Chairman STARK. Thank you, gentlemen. We have a vote. The committee will recess for approximately 10 minutes. First Democrat back gets to play chairman.

[Recess.]

Mr. CARDIN [presiding]. The subcommittee will resume its session. As we get started, I would invite the next panel to please come forward. Ruth Rothstein from the National Association of Public Hospitals, Dennis Cook, the New York City Health and Hospitals Corporation, and John McMeekin from the Crozer-Keystone Health System.

The entire written statements from the witnesses will be made part of the committee record. You may proceed as you so desire. We will start with Ruth Rothstein.

Welcome.

STATEMENT OF RUTH ROTHSTEIN, CHIEF, COOK COUNTY BUREAU OF HEALTH SERVICES, AND DIRECTOR, COOK COUNTY HOSPITAL, CHICAGO, ILL., ON BEHALF OF NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Ms. ROTHSTEIN. Good morning. Thank you so much. As you have said, I am Ruth Rothstein and I am the chief of the Bureau of Health Services for Cook County, Chicago's public health care delivery system. I am pleased to testify before this committee on behalf of the National Association of Public Hospitals whose members include over 100 of America's urban safety net hospitals. While I speak from my own experience, Chicago and Cook County are facing health care problems that are similar to those of many other large cities and rural America as was expressed earlier by the speakers.

Diseases like tuberculosis and syphilis, conditions that were thought to have been controlled or eradicated are now looming again as significant public health problems, and inner-city infant mortality rates continue to be higher than the national average, fueled in part by the emergence of AIDS and cocaine addiction as conditions that are affecting our children.

The lack of access to basic primary care is a major reason why people are dying too early of diseases like cancer, heart disease, asthma, hypertension and diabetes. AIDS, trauma associated with violence, and substance abuse related conditions have assumed prominence as major contributors to the morbidity and mortality of the urban poor.

Let me place you in Cook County for just a moment, Cook County Hospital specifically. At Cook County we deliver over 750,000 outpatient visits per year and in our emergency room we deliver more care than the next three busiest Chicago hospitals combined. We provide AIDS services for approximately 40 percent of the people with AIDS in Chicago and 80 percent of the women and children with AIDS and we have the largest trauma center in the State of Illinois.

Our neonatal services are the high risk referral hub for seven community hospitals, and we also operate a long-term care facility of approximately 900 beds, a public health department, and the health care services for the largest single county jail facility in the country.

Next month we will open a 243 bed community hospital on the south side of Chicago, which is about 15 miles away from our current hub of Cook County Hospital. This hospital has been closed for 6 years and we have rehabilitated it and will be opening it to serve an underserved population. Finally, we operate many community clinics throughout the city and the suburbs. Cook County Hospital is over 85 years old and we continue to operate in a physically dysfunctional physical plant.

The hospital, our hospital is actually a complex of 13 buildings connected by a maze of tunnels in which patients are transported. It is said that our nurses walk anywhere from one to two blocks to take care of patients in our large wards.

Cook County, however, except for its physical plant, is no different from Jackson Memorial, Miami or Parkland Hospital in Dallas or Charity Hospital in New Orleans, and your attention in this

hearing to the urgent needs of America's urban health safety net has never been more welcome or more necessary at this particular time. As you know, the number of uninsured Americans grew from 34 million uninsured in 1988 to 37 million Americans last year.

It is also now estimated that another 20 to 30 million are underinsured, and many of these disenfranchised come to public hospitals as their only source of health care. Public hospitals today are providing an extraordinary volume of inpatient and outpatient care. Some 72 National Association of Public Hospitals members across the Nation average 260,000 emergency room and outpatient visits and 18,000 admissions in 1990, or over 10 times the volume of the average American hospital.

Trauma centers, high risk obstetric units, emergency psychiatric service, emergency drug abuse centers, burn centers, neonatal intensive care units, all are overflowing at a time when State and local budget crises often require reductions, not increases in funding.

In short, while we continue to delay the debate over expanding health coverage, the Nation's public hospitals are providing the major care for uninsured patients, and they are providing it to more and sicker people than at any time in our Nation. Why is the light on?

Chairman STARK. You have got to make three-point baskets from here on.

Ms. ROTHSTEIN. I am very good at that. Is that to tell me—

Chairman STARK. They do it in the inner-city real well.

Ms. ROTHSTEIN. We really have. I am going to keep going in spite of it. How have we as a Nation responded to this growing health care crisis? Our failure to provide universal health coverage has been for years the single most glaring deficiency of our fragmented delivery system, and in the past two decades alone, there have been over a dozen major national health insurance initiatives, many offered by the most important political leaders of our area.

Unfortunately, each of those proposals has generated influential opposition as well as virtually paralyzing all efforts to achieve reform.

I want to talk a little bit about what I believe we need to be looking at as we look at universal health reform. We need to be looking at a universal and mandatory coverage, because voluntary coverage will simply fail to reach many of the most vulnerable in our society. As there will always be individuals who will fall through the cracks and an institutional safety net of hospitals, community health centers and other providers will need to remain in place and be publicly financed to serve these patients.

We need a comprehensive benefit package. Incentives should be in place for the provision of primary and preventive care services. We need a broad array of financing mechanisms for universal health coverage. We need to continue the disproportionate share hospital adjustments, and we are concerned about reports that current Medicaid patients may remain outside the system that will be proposed by the Clinton administration, with inadequate payment rates locked in at current levels and no obligation on the part of new affordable health plans to enroll them.

We believe that such a generalization of Medicare patients will perpetuate and even make worse discrimination that already occurs against Medicaid patients. Inadequate payments will further stop those safety net plans and providers who remain willing to serve them.

We want to thank Chairman Stark for his bill that he introduced yesterday. It was one that was put forward last year. It was one that I did read and I am excited about it and I just wish that we can make sure that this new bill, the Essential Health Facilities Investment Act, will truly pass.

I think I will stop. You have my testimony—

Chairman STARK. Keep going. You are on the right track.

Ms. ROTHSTEIN. Can I go on? You are wonderful. Hey, that is pretty good. OK, while we recognize that there are powerful forces compelling the need for deficit reduction this year, we ask only that you continue to pay careful attention to the impact that Medicare and Medicaid reductions, programs which represent the only significant source of insurance revenue for our safety net hospitals.

As the debate over universal health coverage continues, it is imperative that the Congress enact some form of nationwide institutional support for our public institutions.

I hold too dearly that this should take the form of a national uncompensated fund, a trust fund with dedicated sources of revenue, and that is the legislation that you, Chairman Stark, are most interested in.

Other targeted public health programs and resources that we are proposing or supporting, including proposals to improve the ability of safety net providers to train and employ minority health professionals and inner-city residents. We also propose that any health plan develop and finance regional provider networks that include a full range of services, including ambulatory and preventive care in addition to acute inpatient care, and assist essential providers to participate in managed care programs and initiatives. Finally, you must also continue to fund new services aimed at high risk population, including drug dependent mothers and babies, patients and providers in danger of contracting drug-resistant tuberculosis, prisoners, low income children with chronic diseases such as asthma, and victims of domestic violence and child abuse.

Public hospitals will continue to be the safety net for the Nation and will attempt to be as creative and as productive as possible in that role. In Chicago, we are attempting to deliver health care services that are more effective for the patient and more efficient for the taxpayer.

The establishment of community based primary care facilities is a top priority. Geographic areas have been targeted based on need and level of reliance on the Cook County Hospital emergency room for primary care services. Partners have been sought, including private hospitals, community health centers and city clinics to collaborate on the development of community based systems of care.

District health councils, bodies of consumers and providers have been established in each target community to oversee the local planning and the formation of these networks. Other public hospitals are taking similar leadership roles in the creation of delivery

systems at the local level which most effectively address the health care needs of the most vulnerable residents of our community.

We obviously need your help to continue this important and vital work both today and under national health reform.

I want to thank you very much for enabling me to speak to you today, and if I can answer any questions, I will be glad to.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

**Statement of Ruth Rothstein
Chief, Cook County Bureau of Health Services
Director, Cook County Hospital**

Testifying on Behalf of

National Association of Public Hospitals

before the

**Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington D.C.
June 24, 1993**

I am Ruth Rothstein, Chief, Cook County Bureau of Health Services and Director of Cook County Hospital. The Department includes Cook County Hospital, a 918-bed public teaching hospital, as well as a wide variety of other facilities and services that I will describe in greater detail in my testimony. I am also pleased to testify today on behalf of the National Association of Public Hospitals (NAPH), whose members include over 100 of America's metropolitan area safety net hospitals.

I am pleased to have this opportunity to testify before the Committee on the situation of America's urban healthcare systems today. I would also like to comment on the needs and concerns of urban safety net hospitals with respect to national health reform.

In particular, I would like to accomplish four things in my testimony this morning:

- First, I would like to describe the urban health situation in Cook County today, and provide you with some specific details about the Cook County health system and the broader network of providers that is forming to address the very urgent and immediate needs of Cook County residents.
- Second, I would like to bring you up to date more generally on the situation of America's urban safety net hospitals, including the substantial and increasing volume of services they provide to the poor and uninsured and the growing crises they face in maintaining their services, funding sources and infrastructure.
- Third, I will set out a number of NAPH's recommendations and concerns with respect to national health reform, to assist you in preparing to consider the recommendations that will soon be forthcoming from President Clinton and any other plans that may be on the table.
- Fourth, and finally, I would like to call your attention to the more immediate needs, including serious capital infrastructure needs, facing our nation's urban health safety net. I would also like to urge your support, in both the short and long term, for programs to guarantee the continued viability of this safety net, so that our nation's urban residents will have access to needed health services WHETHER OR NOT they are ultimately covered under any national health plan.

THE SITUATION OF COOK COUNTY'S HEALTH SYSTEM

Chicago and Cook County are experiencing health care problems that are similar to those of many other large urban areas. Diseases like tuberculosis and syphilis, conditions that were thought to have been controlled or eradicated, are now looming again as significant public health problems. Infant mortality rates continue to be higher than the national average, fueled in part by the emergency of AIDS and cocaine addiction as conditions that are impacting our babies. The lack of access to basic primary care in inner city neighborhoods is a major reason why people die too early of disease like cancer, heart disease, asthma, hypertension and diabetes. AIDS, trauma related to violence and substance-abuse related conditions have assumed prominence as major contributors to the morbidity and mortality of the urban poor.

The Cook County Bureau of Health Services represents a comprehensive array of public facilities and programs. Cook County Hospital, one of the oldest public hospitals in the country, provides over 750,000 outpatient visits annually and its emergency rooms deliver more care than the next three busiest Chicago hospitals combined; AIDS services for approximately 40% of the people with AIDS in Chicago and 80% of the women and children with AIDS; the largest trauma service in the state, delivering care to more than 4300 people every year, one half of them victims of gunshot or stab wounds, and acute inpatient care whose general medicine division saw an increase in admissions of approximately 42% from 1991 to 1992. Every day approximately 2500 patients come into Cook County Hospital and, of that number, about half will have no source of government or private insurance. Cook County Hospital is also the site of medical education programs which account for approximately 500 physicians in training in the facility at any one time. The Bureau also operates a longterm care facility of approximately 1100 beds, a public health department which has seen a 50% increase in the number of public health encounters that it has provided in the suburbs over the last two years, and the health care services for the largest single County jail facility in the country. The Bureau will be reopening a shuttered community hospital as a community teaching hospital on the south side of Chicago next month. Finally, the Bureau operates community clinics throughout the City and its suburbs.

The Bureau of Health Services has initiated several innovative programs in an attempt to deliver health care services that are more effective for the patient and more efficient for the taxpayer. The establishment of community based primary care facilities is a top priority. Geographic areas have been targeted based on need and level of reliance on Cook County Hospital emergency room for primary care services. Partners have been sought, including private hospitals, community health centers and city clinics, to collaborate on the development of community based systems of care. District Health Councils, bodies of consumers and providers, have been established in each target community to oversee the local planning and the formation of these networks. In addition, the Bureau operates a "Neighborhood Referral Program" which actively seeks community based referrals for patients who rely on Bureau hospital emergency rooms for care. The Bureau has also formed a solid alliance with the Chicago Department of Health to minimize duplication of services and to maximize the potential impact of our two agencies in addressing the major public health problems plaguing our city.

As the Bureau attempts to be innovative and to streamline its operations, a continuing problem is the physical plants in which we must deliver services. Cook County Hospital is over eighty years old. Studies and reports have called for its replacement since 1932. There is no air conditioning in most of the wards, making it uncomfortable for patients and staff alike and, for those patients who must be isolated for any period of time with such conditions as tuberculosis, nearly untenable. Nurses must walk as far as a full city block from the work station to the last patient on the ward. Power is inadequate to handle monitoring equipment at every bed so patients are constantly being shifted around to make room for the sickest people. The hospital is actually a complex of thirteen buildings connected by a maze of tunnels in which patients are transported. In addition to accommodating the hospital's operational inefficiencies with added staff, the County must spend an estimated \$25 million per year patching up the hospital merely to keep it accredited. Cook County Hospital is only

one facility with significant capital needs. The Bureau operates clinics in cramped buildings never designed for the purpose or the volume. The health services at Cook County Jail were designed to accommodate an average census of 6,000 and are now stretched to care for more than 9,000 in the jail at any one time.

The County's health budget has had difficulty investing in large capital projects because of the increasing pressure of simply maintaining services to a growing population of uninsured residents. In 1992, for example, the Illinois Department of Public Aid eliminated medical benefits for single, non-disabled people without small children. This move alone impacted nearly 35% of Cook County Hospital's patients and increased the burden on County government. Despite the obstacles however, we are determined to stop the drain of dollars resulting from continuing to operate an inefficient hospital and find the way to replace Cook County Hospital with a new, smaller facility which is the centerpiece of a system of care rooted in community based primary care facilities.

THE SITUATION OF AMERICA'S URBAN HEALTH SAFETY NET

I would now like to bring you up to date on the situation of urban public hospitals generally in America today.

Mr. Chairman, we believe that NAPH's 100 member institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over \$14 billion, these hospitals provide over 65% of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as "national health insurance" by default in most of our nation's urban areas.

Your attention in this hearing to the urgent needs of America's urban health safety net has never been more welcome or necessary. This safety net is increasingly threatened today by a combination of factors.

Let me illustrate the urgency of this situation with a few simple facts:

- **The numbers of uninsured have dramatically increased in recent years.** Despite all our rhetoric about reform, the number of completely uninsured Americans grew from 34 million uninsured in 1988 to 37 million last year. It is also now estimated that another 60 million are insured only part of the year, or have health insurance that will prove inadequate in the event of a serious illness. This is not just a temporary trend brought on by the recession: it has been exacerbated by disturbing trends among employers and insurers to reduce or eliminate coverage for many among the insured, including dependents, retirees, and individuals with AIDS and other serious medical problems.
- **Safety net hospitals are bursting at the seams.** Such hospitals today are providing an extraordinary volume of inpatient and outpatient care. 72 NAPH member hospitals across the nation averaged 260,000 emergency room and outpatient visits and 18,000 admissions in 1990 -- or over ten times the volume of the average American hospital. NAPH member hospitals totalled 18.7 million emergency and outpatient visits in 1990. NAPH members averaged an 82% occupancy rate in 1990, also far higher than other hospitals, with many safety net hospitals approaching 100%.
- **Safety net hospitals are both hospital and family doctor for the uninsured.** In 1990, 33% of all discharges and 30% of all inpatient days were not sponsored -- even by Medicaid -- in NAPH member hospitals; 48% of all outpatient and emergency room visits were also uninsured.
- **Safety net hospitals are uniquely reliant on governmental funding sources.** Just 17% of the gross revenues of safety net hospitals were derived from private insurance and 18% from Medicare in 1990, while 67% were attributable to Medicaid and "self pay" patients. Medicaid charges for NAPH members averaged \$73 million

and charges for "self pay" patients averaged \$69 million in 1990. Typically, "self pay" is a euphemism for "no pay", and the only sources of payment for these patients are direct local subsidies and Medicare and Medicaid "disproportionate share hospital" ("DSH") adjustments.

- **Emergency and clinic patients are waiting longer to see doctors or be admitted.** 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.
- **The many community-wide services provided by safety net hospitals are in danger of deterioration as well.** Trauma centers, high risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units -- all are overflowing, at a time when state and local budget crises often require reductions, not increases, in funding.

In short, while we continue to delay the debate over expanding health coverage, the nation's Safety Net hospitals are providing care for uninsured patients **now**, and they are providing it to more and sicker people than at any other time in our nation's history.

NAPH COMMENTS ON HEALTH CARE REFORM

Our failure to provide universal health coverage and access to care has for years been the single most glaring deficiency of our nation's health system -- one we share only with South Africa among Western nations. In the past two decades alone, there have been over a dozen major national health insurance initiatives, offered by the most important political leaders of our era, as well as scores of more modest proposals. Unfortunately, each of these proposals has generated influential opposition as well, virtually paralyzing all efforts to achieve needed reform. As a result, we have advanced very little in this arena since the enactment of Medicare and Medicaid.

Our nation's lack of universal health coverage is forcing safety net hospitals to treat an ever-broader population of Americans who have no access to other providers because they have lost their jobs, their insurance, or both. Rarely are these individuals able to become eligible for Medicaid -- yet rarely can they afford the cost of a serious illness either.

Being a relatively small organization, NAPH did not choose in the past to adopt a single, comprehensive proposal of our own, but rather to outline the characteristics we would like to see in any national health plan that is adopted by the Congress, or by a state. More recently, with the dramatic improvement in the prospects for health reform, NAPH has chosen to expand on those general principles -- to offer more specific and detailed suggestions in a number of areas, based on our intimate knowledge of the health status, and the broad range of both health and social needs, of America's urban uninsured.

Based on what we have learned about the general thrust of the plan under development by the Clinton Administration -- and the excellent work of Chairman Stark and the members of this Committee in recent years -- we would like to make the following observations and recommendations at this time:

1. ELIGIBILITY

A. The goal of national health reform must be nothing less than **universal and mandatory coverage for all residents**. While universality is generally acknowledged as a worthy goal, there appears to be debate over whether coverage should be voluntary or mandatory for employers, employees and the uninsured. The experience of NAPH members in many states makes clear that voluntary coverage will simply fail to reach many among the uninsured -- including many of the most vulnerable individuals and families. It is well accepted that in many states, the Medicaid program (which is voluntary) enrolls less than half of all potentially eligible patients.

Only by requiring all individuals to be covered can a new system lead to genuine reforms. At the same time, care will need to be taken that such a requirement will not carry with it and unrealistic burden of co-payments and deductibles for low income patients. Even those with incomes of up to 200% of poverty will have an extremely hard time meeting such co-payments -- which means that they will become bad debts, requiring new forms of cost shifting, for the providers that serve them.

B. It will clearly be necessary -- if only for budgetary reasons -- for universal health coverage to be phased in. In that case, it is important that **the most vulnerable populations among the uninsured should be covered first** -- including the chronically or seriously ill, as well as women and young children not otherwise eligible for Medicaid. Among the employed uninsured, particular attention will need to be paid to dependents, part time employees, and seasonal and migrant employees, to prevent these populations from falling through the gaps.

C. We are concerned about reports that current Medicaid patients may remain outside the system that will be proposed by the Clinton Administration -- with inadequate payment rates locked in at current levels and no obligation on the part of new affordable health plans to enroll them. Such a "ghettoization" of Medicaid patients will perpetuate (and make worse) the discrimination that already occurs against Medicaid patients. Inadequate payments will further starve those safety net plans and providers who will remain willing to serve them.

D. It is also essential to recognize that, however noble the goal of universality, **there will always be coverage gaps** and individuals who fall through them. An institutional safety net, including hospitals, community health centers, and other providers, will need to remain in place (and be publicly financed) to serve these patients. Even Hawaii's much-touted health plan has gaps -- as is evidenced by the continued existence of a state-subsidized public hospital system.

E. It is imperative that (unlike Medicaid, AFDC and food stamps today) **the eligibility process should be kept as simple as possible**. In many cases, as our experience with Medicaid demonstrates, individuals who may otherwise be eligible -- especially in inner cities and isolated rural areas -- will simply not sign up for a new national health plan, even if mandatory. Rather, they will present themselves to providers in the future as they do today -- sick or injured, addicted or mentally ill, homeless, often unable to provide us with basic information about themselves. As eligibility is phased in for various groups, providers must be able to rely on the presumptive eligibility of any individual who shows up in the emergency room.

F. It is important to understand that simply giving a patient a card will not ensure that his or her needs will be met. A dramatic recent indication of that fact occurred last year in Milwaukee, when well over 200 children were hospitalized (and several died) as a result of a measles epidemic that could have been prevented through simple immunizations. **Over two thirds of the children hospitalized were enrolled in Medicaid managed care plans!**

2. BENEFIT PACKAGE

A. A basic benefit package and "basic risk pool" should be developed, based on the mandatory federal Medicaid benefit package, but with a **greater emphasis on (and first dollar coverage for) primary and preventive care**. For cost containment purposes and so that it may be applicable to the widest possible population, the basic package should include catastrophic limits (in effect, a "stop loss") on hospitalization and high tech providers and treatments.

B. As with eligibility, any system of health reform must acknowledge that there will be a number of services whose costs will continue (in whole or in part) to fall outside either benefit package. These services will range from costly 24-hour

standby services such as trauma, burn care, and neonatal intensive care, to traditional public health and even non-health social services that are often needed by low income patients whether or not they have coverage. **These safety net and community-wide services must continue to be provided and funded outside the health insurance system**, through add-on community service payment adjustments or through direct grants or subsidies.

3. FINANCING HEALTH REFORM

A. NAPH strongly supports a **broad array of financing mechanisms for universal health coverage**, including taxes on excess employee health coverage, so-called "sin taxes" on alcohol and tobacco, sliding scale cost sharing for higher income insured individuals, and increased Medicare cost sharing.

B. NAPH agrees that **cost containment must be an essential element** of any national health plan, and would support cost containment methodologies that are applied equitably across all insurers and providers (rather than being limited only to public programs). To be effective, cost containment strategies must be administered locally, at the community level, and should not penalize efficient providers (but rather, should target underutilized or otherwise inefficient providers).

C. In recent years, the so-called "disproportionate share hospital" ("DSH") adjustments paid by Medicare and many Medicaid programs have been of particular importance in helping safety net hospitals make ends meet, assisting overburdened local governments in preserving and improving health safety net services. There has been some talk of using these adjustments as a "funding source" for national health reform. However, we believe it is essential that these adjustments be continued and strengthened until such time as other sources of funding are available **AND FULLY PHASED IN** for the presently uninsured.

D. We further believe that many residual community-wide public health and social services will continue to be needed even after most uninsured Americans have been provided some form of health coverage. Such services will range from emergency "standby" services such as trauma centers, burn centers, neonatal intensive care, and the like, to public health and social services that will still be needed by low income patients. For this reason, as part of health reform, NAPH is proposing the identification of "essential community providers" -- both clinics and hospitals -- that will continue even under a new national health plan to provide these community-wide services. We are concerned with reports that, while the Clinton Health Task Force may recommend adoption of such an ECP definition, it may not include urban public hospitals within such a definition. Failure to include hospitals as well as clinics and other providers would betray a gross ignorance of the limited access of many millions of inner city residents to adequate health care today -- and of the fragile and under funded health system that serves them.

E. Development of an adequate definition of ECP could be accomplished through an expansion of the EACH concept that Chairman Stark has championed so effectively in the past. We would further recommend special treatment under any sort of "managed competition" that may be adopted, and the phase-in of a separate "Community Services Adjustment" that would be carefully targeted on such essential community providers.

4. PLAN ADMINISTRATION

A. NAPH believes that the concept of "managed competition" should be given an opportunity to work wherever it may prove to be feasible. However, based on our extensive experience serving the urban uninsured, we are concerned that managed competition as described in the literature to date may be less effective in some areas, including inner cities and isolated rural areas. This is true for several reasons,

including the dearth of a sufficient number and variety of providers to guarantee access and choice in those areas; the checkered history of efforts to introduce competitive models (such as the California PHP scandals of the early 1970s and the Florida scandals of the 1980s); and the nature of the patient population itself in such areas.

B. It must be further recognized in implementing "managed competition" that the playing field is not currently level for either providers or patients -- especially in the inner cities and remote rural areas. To be equitable, and to guarantee access for patients in such areas to the broadest range of health and social services, a plan must ensure that all safety net providers (including health centers as well as public hospitals) are given an equal opportunity to develop and participate in competitive plans.

C. If managed competition is adopted, with "HIPCs" or "health alliances" serving as brokers for the poor, there must be significant safeguards against abuses by insurers and others who may develop plans to be offered under this system. Of particular concern is the possibility of adverse selection and "targeted marketing" by some plans -- cream-skimming, if you will -- that will leave the sickest and the poorest to enroll in "public plans". NAPH will be developing a detailed list of possible safeguards, including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients.

D. NAPH supports the broadest possible range of insurance industry reforms, including full portability, a ban on preexisting conditions, and community rating for all plans and all employers.

MEETING THE MORE IMMEDIATE NEEDS OF URBAN SAFETY NET HOSPITALS

Many supporters of various national health reform proposals have suggested that, if reforms were enacted, there would no longer be a need for an institutional health safety net. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the strong likelihood that future changes will continue to be incremental and piecemeal, NAPH believes that there will continue to be a strong need for the public health safety net in our nation's metropolitan areas.

In particular, as the crisis just one year ago in South Central Los Angeles clearly underscores, our current health safety net is extremely fragile and underfunded today. The health safety net in Los Angeles, consisting largely of county facilities and programs, worked well during the riots. Reports tell of extraordinary heroism and dedication by County medical and administrative staff, especially at the Martin Luther King/Drew Medical Center, in the middle of the war zone. Safety net hospitals were flooded with hundreds of casualties -- without their standby readiness, the death toll would have been far higher than it was, and many of the injured would have been far worse off as well. But it was clear that the County system in Los Angeles was stretched to the very limit. And it was also clear that health insurance coverage alone would never have financed the full range of emergency system, trauma network, public health and social costs of meeting the community's needs during this crisis.

Safety net providers were also the first -- and in some cases only -- responders to many other significant urban and rural health crises in the last year. Three public hospital systems in South Florida provided the vast majority of health services in the days and weeks following Hurricane Andrew last fall. The Emergency Medical Services division of the New York City Health and Hospitals Corporation was commended for extraordinary heroism and responsiveness following the World Trade Center disaster earlier this year. As recently as two weeks ago, in the wake of harrowing reports of a new and mysterious epidemic on the Navaho Indian Reservation, it was the public health clinics, hospitals and personnel that were there to provide the extraordinary care and to fearlessly lead the search for the possible

sources of the epidemic. Time after time, it is our urban safety net institutions that are on the frontlines -- in the fights against AIDS, substance abuse, gang violence, drug resistance tuberculosis -- the list goes on and on.

Can we really afford to imperil this safety net today -- even in the name of deficit reduction and health reform? I think not. We must thus be extremely careful about dislodging any current funding mechanisms for public health systems in general, and safety net hospitals in particular, unless we are certain that we have workable and fully implemented NEW systems and funding sources to take their place. Moreover, we must continue to press forward with more targeted programs and reforms that support "stand by" health and social services and safety net providers.

For many reasons, even if national health insurance were adopted this year, America's safety net institutions will need continued support well into the future:

- Any new health reform system is likely to be phased in over a long period of time.
- Even with coverage, many of our current uninsured will be little better off than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.
- It is also important to recognize that many of the current uninsured also suffer from a variety of health and social problems very different from those of middle America -- AIDS, drug abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education; while no health care provider can fully cope with all of these problems, our urban safety net hospitals are the only ones even trying to do so today.
- In addition, we must recognize that even for insured individuals today, with the dramatic cost containment efforts already being imposed by both public and private payers, many expensive and unprofitable "standby" services (such as trauma, burn care, and neonatal intensive care) are also far more likely to be available in safety net hospitals.
- Finally, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside -- areas which, even if national health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.

Mr. Chairman, there are many other more immediate needs for safety net hospitals. These include capital financing (something of critical concern to Cook County Hospital), the preservation of Medicare Disproportionate Share and Medical Education adjustments, and the improvements and expansions of the Medicaid program. Regina Morris, Vice President of New York City's Health and Hospitals Corporation will discuss in her testimony many of the immediate issues of concerns to all NAPH members.

I would be pleased to answer any questions you might have at this time.

STATEMENT OF REGINA MORRIS, CHIEF OPERATING OFFICER, AS PRESENTED BY DENNIS COOK, SENIOR VICE PRESIDENT FOR FINANCE, NEW YORK CITY HEALTH AND HOSPITALS CORP.

Chairman STARK. Mr. Cook.

Mr. COOK. Good morning, I am Dennis Cook, the senior vice president and chief financial officer of the New York City Health and Hospitals Corp., the Nation's largest municipal public hospital system.

Chairman Stark, I want to thank you and the other members of this subcommittee for the opportunity to speak. Today I want to talk to you about the complex problems HHC faces in caring for New York City's medically underserved people and how you can help us improve their health care.

Let me emphasize that only the magnitude of HHC's problems are unique. Every safety net hospital in the country confronts similar issues in their efforts to improve service.

Let me begin by telling you a bit about HHC. We operate 11 acute care hospitals, 5 long-term care facilities, 6 major community health centers, a growing network of smaller clinics, approximately 30 to date, 6 home health agencies, an HMO and New York City's emergency ambulance service.

In 1992 there were over 4.5 million visits to our clinics, more than 1 million visits to our emergency rooms and over 210,000 admissions to our hospitals. Our budget is \$3.2 billion, and our hospitals are major employers in New York City's most economically distressed neighborhoods.

We employ approximately 50,000 people. While HHC's size is imposing, ultimately the corporation is not about visits, dollars or buildings. It is about caring for people who lack the means to pay for their own treatment. Almost 90 percent of our patients are on Medicaid and have no insurance. The fastest growing segment of our patient population are immigrants and nearly 88 percent of our patients are minorities.

HHC's patients, like the patient populations of virtually every other safety net hospital, suffer disproportionately from all the health problems found in our inner cities. Hopelessness, lack of opportunity, poverty, violence, and substance abuse all contribute to poor health. Our patients are sicker than the population as a whole.

A high percentage have multiple diagnoses and chronic disabilities. With only 20 percent of New York City's hospital beds, HHC serves 35 percent of its AIDS patients and 40 percent of those with TB. We are the city's largest provider of mental health and substance abuse programs.

Health care reform and the role of HHC. Many proponents of national health care reform argue that universal service will end or substantially diminish the need for the kind of safety net hospitals operated by the corporation. This will not be the case.

Much the same argument was made when Medicare and Medicaid came into being. Safety net hospitals continue to play a vital role in New York City's health care delivery system. Private doctors, hospitals, insurers, clinics and HMOs are not competing for patients in the South Bronx, Bedford Stuyvesant, or in other New

York City's low-income neighborhoods. We treat 40 percent of New York City Medicaid population and without the corporation, without HHC, it is hard to imagine how our patients will be served.

There will be a strong, ongoing need for public hospitals in urban and rural areas. They are and will continue to be the first and in some cases the only responders to significant emergencies. Our hospitals also continue to be the primary providers of expensive and unprofitable standby trauma, burn care, and neonatal intensive care services.

Primary care. There is much discussion on the need to change how we finance health care. However, changing the way we deliver health care is also important. Patients come to our emergency rooms because they lack the one thing that most Americans take for granted, a family doctor. Fifty percent of the common problems we see in our emergency rooms are earaches, colds, and asthma, which should be treated in an ambulatory care setting.

Through Mayor David Dinkins innovative Communicare program we are beginning to expand primary care services. Soon there will be 20 Communicare clinics giving patients their own doctor and access to care 24 hours a day, 365 days a year. Ten of HHC's clinics are already open and this year we will provide an additional 68,000 primary care visits.

Yet for all that we have achieved, we are responding to less than 5 percent, 5 percent of the demand for primary care. Estimates indicate that New York City requires an additional 4.2 million primary care visits a year. No one hospital system, no one city and no one State, no matter how committed or generous, could hope to respond to that level of demand.

Universal access to care does not by itself mean access to available, appropriate services. Underserved communities in urban and rural areas need targeted Federal support to build their primary care infrastructures.

Furthermore, HHC and other safety net providers—can I keep going also? I am almost done.

Furthermore, HHC—

Chairman STARK. I am waiting until you get to that part where you say something nice about my bill.

Mr. COOK. That's the grand finale.

Furthermore, HHC and other safety net providers treat increasingly diverse groups of people. At present, our patient population speaks 150 different languages and dialects. Thus Federal funds should also be available to train more culturally competent medical professionals.

Disproportionate share. Safety net hospitals confront special problems in caring for our patients. We assume a heavy financial burden that is often referred to as disproportionate share.

Over the years Congress has done much to help HHC and other safety net providers address the needs of Medicaid and Medicare patients. We hope that current efforts to reduce the Federal deficit do not undermine this support. Reductions in Medicaid and Medicare can have a devastating impact on safety net hospitals. As Congress moves toward final passage of the budget, I ask you to pay careful attention to how changes in Medicare and Medicaid will affect us.

Graduate medical education. Closely related to our concerns about reductions in Medicaid and Medicare are proposals in the Senate's version of the Budget Reconciliation Act to cut funds for graduate medical education. While significant changes are needed in how we train physicians, we need to avert reductions that will have an immediate negative impact on our ability to serve patients.

Hospitals are heavily dependent on residency training programs for service delivery. A sharp cutback in GME funding will quickly leave us without alternatives in the short run. We appreciate the changes you made in the President's budget proposals and ask your help in averting the cuts proposed by the Senate.

Capital funding. Like other safety net providers, HHC's facilities are very old. The newest of our facilities are in fact older than the average of voluntary hospitals in this country. The oldest were opened in the 1920s. If we are to deliver effective, modern care, many of our facilities must be rebuilt or extensively renovated.

While we have begun to do this, neither HHC nor New York City is capable of generating the capital dollars needed to complete the effort. Again, we are not unique in this respect.

A new NAPH study estimates that there are nearly \$15 billion in unmet capital needs across essential urban providers. To meet them, a new Federal capital financing initiative is clearly required, and let me thank you, let me thank you, Congressman Stark, for introducing a major new hospital capital financing initiative again this year.

Direct operating support for safety net hospitals. Congress needs to consider providing direct operational support to safety net hospitals both now and after national health care reform is adopted.

As I have already noted, public hospitals confront special problems and they will not go away. Our patients will remain sicker. They will continue to require a variety of special services, including social services, transportation and translation.

HHC, for example, was particularly concerned about the expanding role that safety net hospitals are playing in caring for undocumented immigrants. These individuals are a growing segment of our patient population and I know that other public hospitals are experiencing similar increases.

As you will no doubt recall, 2 weeks ago a boat carrying undocumented aliens from China ran aground off the Rockaway Peninsula in Queens. Several of those people on that ship needed care and HHC provided treatment.

A large sum of money is involved. It has been estimated that even if national health care insurance becomes a reality, 10 percent of those people living in New York City would still be uncovered at any given time. In 1990 the city's office of management and budget estimates that if the cost of caring for undocumented immigrants is not included in health care reform, HHC would face additional costs of approximately \$400 million.

Quite frankly the Federal Government is responsible for all aspects of immigration. It should pay for the health needs of undocumented immigrants.

In conclusion, over the years the members of this subcommittee have been effective leaders in developing a Federal response to the

health needs of poor Americans. On behalf of the tens of thousands of New Yorkers we assist, I thank you.

Now, as we begin reforming our health care delivery system, your experience and expertise will be needed more than ever. With your assistance, all Americans regardless of their ability to pay can have access to comprehensive health care.

Hopefully national health care reform will allow this country to make better use of our safety net hospitals. We look forward to working with you on this initiative.

Thank you. I hope I didn't go over too much.

Chairman STARK. Thank you.

[The statement of Regina Morris follows:]

STATEMENT OF REGINA MORRIS, CHIEF OPERATING OFFICER,
NEW YORK CITY HEALTH AND HOSPITALS CORP.

INTRODUCTION

Good Morning. I am Regina Morris, Chief Operating Officer of New York City's Health and Hospitals Corporation (HHC), the nation's largest municipal public hospital system. Chairman Stark, I want to thank you and the other members of this Subcommittee for the opportunity to speak. I am here representing both HHC and the National Association of Public Hospitals (NAPH). Today I want to talk with you about the complex problems HHC faces in caring for New York's medically underserved people and how you can help us improve their health care. Let me emphasize that only the magnitude of HHC's problems are unique. Every safety net hospital in the country confronts similar issues in their efforts to improve services.

Let me begin by telling you a bit about HHC. We operate 11 acute care hospitals, 5 long term care facilities, 6 major community health centers, a growing network of smaller clinics, 6 home health agencies, an HMO and New York's emergency ambulance service. In 1992, there were over 4,500,000 visits to our clinics, more than 1 million visits to our emergency rooms and over 210,000 admissions to our hospitals. Our budget is \$3.2 billion, and our hospitals are major employers in New York City's most economically distressed communities. We employ over 47,000 people.

While HHC's size is imposing, ultimately, the Corporation is not about visits, dollars or buildings. It is about caring for people, who lack the means to pay for their own treatment. Almost 90% of our patients are on Medicaid or have no insurance. The fastest growing segment of our patient population are immigrants and nearly 88% of all our patients are minorities.

HHC's patients, like the patient populations of virtually of every other safety net hospital, suffer disproportionately from all the health problems found in our inner cities. Hopelessness, lack of opportunity, poverty, violence and substance abuse all contribute to poor health. Our patients are sicker than the population as a whole. A high percentage have multiple diagnoses and chronic disabilities. With only 20% of New York City's hospital beds, HHC serves 35% of its AIDS patients and 40% of those with TB. We are the City's largest provider of mental health and substance abuse programs.

HEALTH CARE REFORM AND THE ROLE OF HHC.

Many proponents of national health care reform argue that universal insurance will end or substantially diminish the need for the kind of safety net hospitals operated by HHC. This will not be the case. Much the same argument was made when Medicare and Medicaid came into being. Safety net hospitals continue to play a vital role in New York's health care delivery system. Private doctors, hospitals, insurers, clinics and HMOs are not competing for patients in the South Bronx, Bedford Stuyvesant or in New York's other low income neighborhoods. We treat 40% of New York's Medicaid population and, without HHC, it is hard to imagine how our patients would be served.

There will be a strong, on-going need for public hospitals in urban and rural areas. They are and will continue to be the first, and, in some cases, the only responders to significant emergencies. One need only look at the Martin

Luther King/Drew Medical Center during the Los Angeles riots, at public hospital systems in South Florida after Hurricane Andrew or at our Emergency Medical Service following the World Trade Center bombing to understand how unique a role safety net providers play. Our hospitals also continue to be the primary providers of expensive and unprofitable "standby" trauma, burn care, and neonatal intensive care services.

For me the real question is not whether there will be a need for entities like HHC if we enact national health care reform. It is how this reform can improve our safety net hospitals so they can better fulfill their mission. Let me offer you a number of suggestions that I believe will accomplish this important goal.

PRIMARY CARE

My colleague Ruth Rothstein has already noted the need for more primary and preventive care. There is much discussion on the need to change how we finance health care. However, changing the way we deliver health care is equally important. Patients come to our emergency rooms because they lack the one thing that most Americans take for granted, a family doctor. 50% of the common problems seen in our ERs - like earaches, colds, asthma - should be treated in an ambulatory care setting.

Through Mayor David Dinkins innovative Communicare program we are beginning to expand primary care services. Soon there will be 20 Communicare clinics giving patients their own doctor and access to care 24 hours a day, 365 days a year. Ten of HHC's 13 clinics are already open and this year we will provide an additional 68,000 primary care visits. Yet for all we have achieved, we are responding to less than 5% of the demand for primary care. Estimates indicate that New York City requires an additional 4.2 million primary care visits a year. No one hospital system, no one city and no one state, no matter how committed or generous could hope to respond to that level of demand. Universal access to care does not by itself mean access to available, appropriate services. Underserved communities in urban and rural areas need targeted Federal support to build their primary care infrastructures.

The Federal government spends a good deal of money educating and training doctors. Those dollars should be targeted to increasing the number of primary care providers. In addition, money should be directed toward increasing the number of nurse practitioners and midwives, physician assistants and other professionals who can play a role in expanding access to primary care. New Federal policies are also needed to reward practitioners working in low-income areas. HHC, like other safety net hospitals, is often unable to match the salaries offered by non-public providers. The result is on-going difficulty recruiting and retaining staff. You can help us resolve that problem with new incentive programs.

Furthermore, HHC and other safety net providers treat increasingly diverse groups of people. At present, our patient population speaks 150 different languages and dialects. Thus, Federal funds should also be available to train more culturally competent medical professionals.

DISPROPORTIONATE SHARE

Safety net hospitals confront special problems in caring for their patients. We assume a heavy financial burden that is often referred to as disproportionate share. Over the years, Congress has done much to help HHC and other safety net providers address the needs of Medicaid and Medicare patients. We hope that current efforts to reduce the Federal deficit do not undermine this support. Reductions in Medicaid and Medicare can have a devastating impact on safety net hospitals. As Congress moves toward final passage of the budget, I ask you to pay careful attention to how changes in Medicare and Medicaid will effect us.

Medicare is the single most important non-indigent payor in many safety net hospitals. This subcommittee can take a good deal of pride in its efforts to secure Medicare payment adjustments for disproportionate share hospitals. All of us associated with NAPH thank you for your recognition of the role of safety-net providers. Additionally, although we understand that Medicaid is not within the jurisdiction of this Committee, we want to emphasize how important Medicaid disproportionate share funding is to us for the extra costs of treating the poor.

GRADUATE MEDICAL EDUCATION

Closely related to our concerns about reductions in Medicaid and Medicare are proposals in the Senate's version of the budget reconciliation act to cut funds for graduate medical education. While significant changes are needed in how we train physicians, we need to avert reductions that will have an immediate negative impact on our ability to serve patients. Safety net hospitals are heavily dependent on residency training programs for service delivery. A sharp cutback in GME funding will quickly leave us without alternatives in the short run. We appreciate the changes you made in the President's budget proposals and ask your help in averting the cuts proposed by the Senate.

HHC better than most understands the need for change in the way we provide graduate medical school education. We have created an educational system that trains too many specialists and too few primary care providers. The problems that result from this imbalance falls unduly heavily on the communities served by safety net hospitals. HHC has developed a detailed position paper on how to restructure graduate medical education. It is attached to this testimony.

CAPITAL FUNDING

Like other safety net providers, HHC's facilities are old. The newest of our hospitals are in fact, older than the average age of voluntary hospitals in this country; the oldest were opened in the 1920's. If we are to deliver effective, modern care, many of our facilities must be rebuilt or extensively renovated. While we have begun to do this, neither HHC or New York City is capable of generating the capital dollars needed to complete the effort. Again, we are not unique in this respect.

A new NAPH study estimates that there are at least \$15 billion in unmet capital needs among essential urban providers. To meet them, a new Federal capital financing initiative is clearly required. Let me thank you Congressman Stark for introducing a major new hospital capital financing initiative last year. The measure would cost the Federal government only \$1 billion, but it would create federal-state-local and public-private partnerships to finance up to \$15 billion in capital improvements through loan guarantees, interest rate subsidies, and grants. The bill has been reintroduced in the Senate and I understand Mr. Chairman that you will soon introduce a new House version. We look forward to its enactment.

DIRECT OPERATING SUPPORT FOR SAFETY NET HOSPITALS

Congress needs to consider providing direct operation support to safety net hospitals both now and after national health care reform is adopted. As I have already noted, public hospitals confront special problems. They will not go away. Our patients will remain sicker. They will continue to require a variety of special service including social services, transportation and translation.

HHC, for example, is particularly concerned about the expanding role that safety net hospitals are playing in caring for undocumented immigrants. These individuals are a growing segment of our patient population and I know that other public hospital are experiencing similar increases. As you will no doubt recall, two weeks ago a boat carrying undocumented aliens from China ran aground off the Rockaway Peninsula in Queens. Several of the people on that ship needed care and HHC provided treatment.

A large sum of money is involved. It has been estimated that even if national health insurance becomes a reality, 10% of those living in New York City would still be uncovered at any given time. In 1990, the City's Office of Management and Budget estimates that if the cost of caring for undocumented immigrants is not included in health care reform, HHC would face annual costs of \$395 million. Quite frankly, the Federal government is responsible for all aspects of immigration. It should pay for the health needs of undocumented immigrants.

CONCLUSION

Over the years, the members of this Subcommittee have been effective leaders in developing a federal response to the health needs of poor Americans. On behalf of the tens of thousands of New Yorkers we assist, I thank you. Now, as we begin reforming our health care delivery system, your experience and expertise will be needed more than ever. With your assistance, all Americans regardless of their ability to pay can have access to comprehensive health care. Hopefully, national health care reform will also allow this country to make better use of our safety net hospitals. We look forward to working with you on this initiative.

STATEMENT OF JOHN McMEEKIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CROZER-KEYSTONE HEALTH SYSTEM, MEDIA, PA.

Chairman STARK. Mr. McMeekin.

Mr. McMEEKIN. Good morning, Mr. Chairman and Members of the Subcommittee on Health. Thank you again for the opportunity of appearing before you today. Chairman Stark, I wish to compliment you and your colleagues on the introduction of H.R. 2494.

My name is John McMeekin and I am president and chief executive officer of the Crozer-Keystone Health System located just outside of Philadelphia. We are a new community health network consisting of four acute care hospitals, six long-term care facilities, a managed care organization and a number of ambulatory and primary care services. We are a major provider in Delaware County with a population of 550,000 persons and among the communities we serve is the city of Chester, one of the most severely disadvantaged urban areas in our country.

Your hearings today focus on the important issue of access and availability of care. The question you ask is critical. Does universal entitlement or possession of an insurance card automatically insure access and availability of health care. The answer is simple and straightforward. No.

In addition to my prepared remarks, which I have provided to this committee, I would like to stress three important considerations as you wrestle with this complex social policy issue. The first is the greater need for community outreach and community health education.

If we are to make more appropriate use of those services currently available in our communities, we will need to have better mechanisms to get people to know of and use those services. A recently completed 18-month study of the health needs of our 550 Delaware County population indicates that 2 women a week die of breast cancer in our community despite the existence of at least 10 mammography units.

Over 70 percent of the children in the city of Chester begin school with no immunization despite the existence of several major federally funded initiatives, including the second largest maternal/infant care contract in the State of Pennsylvania.

The message seems clear, having the medical and health care tools and resources available does not guarantee that they will be used. Lifestyle, personal and family health habits are still major determinants of health status, and as Mrs. Rothstein has already said, any new set of health benefits should place greater support and attention on health education, community outreach, community health status evaluation, and somehow we should encourage good personal health habits, at least as consistent as we are with the requirements of our new car warranties.

My second point deals with the organizational structure of health care. Today's fragmented system of delivering care and the lack of integration of both finance and delivery play an unwittingly negative role in the matters of access and availability. Reform must encourage a new organizational form of local financing and delivery that is responsible for providing a seamless continuum of services

to a defined population, including wellness, early detection, and followup.

Today's health care system is not only fragmented but places a higher premium on caring for the sick than it does on health promotion. Tomorrow's model must have an incentive to keep people well.

Mr. Chairman, I must at this point stress the crying need for relief of the antitrust actions that stand in the path of true provider collaboration. Frivolous antitrust suits brought by persons not intent on health reform but rather self-preservation will ultimately kill health care reform. I commend the comments by Congressman Slattery earlier this morning.

Let me conclude my remarks on one last critical topic of reform that has not received much attention and that can play a significant role in assuring greater access and availability of health services.

This is the need for more sophisticated information system development. Part of why entitlement does not guarantee access and availability of needed health services is that we do not have the information systems necessary to track and monitor across our delivery system.

We do not know how health services are used and when appropriate services are not used. Today our health encounter is best tracked in the hospital inpatient setting, while tomorrow we will need to have community-based tracking systems that monitor health status and provide the triggering mechanisms for community outreach and followup. These systems don't now exist.

And we need to assist in their development. Both you, Mr. Chairman and Congressman Slattery, seem familiar with these opportunities that I believe really offer the hope of bringing technology to the inner city and rural communities where it may not be today.

Again, I commend you, Mr. Chairman, for these hearings as they focus on the sad fact that mere entitlement to necessary health services has not reduced infant mortality or lowered the number of babies born in our inner cities with low birth weight and lacking any prenatal care.

Tomorrow's health delivery system must be more proactive and must be properly incentivized to keep people well and must bear some risk when programs often available in our community go unused by those most in need.

I thank you for the opportunity of talking.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF
JOHN MCMEEKIN, PRESIDENT AND CEO
CROZER-KEYSTONE HEALTH SYSTEM
BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS & MEANS
U.S. HOUSE OF REPRESENTATIVES
ON
HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES

JUNE 24, 1993

Good morning Mr. Chairman, and thank you for the opportunity of sharing with you and members of the subcommittee my thoughts on access to and the availability of health services in urban areas.

My name is John McMeekin and I am the President and Chief Executive Officer of the Crozer-Keystone Health System, a community health network serving the Greater Philadelphia Community and more specifically, Delaware County and its 550,000 population.

Crozer-Keystone Health System was formed in 1990 in response to our growing recognition of the need and opportunity to build a new and more efficient, user friendly community health network. It now consists of four acute care hospitals totalling 1165 beds, six long term care facilities of over 1000 beds and a variety of free standing ambulatory and diagnostic centers, including a jointly owned MRI Center with a neighboring health system and a multi-hospital sponsored residential substance abuse center. We have also formed a network of primary care physician office sites in underserved areas of our community.

The Vision of Crozer-Keystone Health System is that of a seamless continuum of quality health services, including health promotion and early detection, acute, restorative and long term care. We believe and stand ready to accept responsibility for improving the overall health status of the communities we serve through documented outcome measurements.

We are intent on building a true clinical and economic partnership with our 800 physicians, and, as well, a partnership with our patients that will build on their active and knowledgeable involvement in their own health status. Last year we formed a joint venture with our physicians creating Managed Care Enterprises, Ltd., through which we can enter into risk-bearing contracts for the provision of total services to a defined population.

The creation of Crozer-Keystone Health System, and countless other community health networks being formed across our country, was to achieve economies of scale, to share and better distribute expensive medical technology and clinical specialty care and to enable us to more actively engage in health promotion and health maintenance efforts in response to escalating health care costs and growing community disenfranchisement and access to basic health care services.

We recognized that to assume greater responsibility for health status of our county of our community would require an accurate assessment of their current health status. After 18 months of data collection, focus group interviews, and more than 2000 households interviews our community health needs assessment, Delaware County - Health Priorities 2000 was published and broadly distributed last October.

Not surprising, our Community Health Needs Assessment, while documenting severe problems related to heart disease, cancer and sexually transmitted diseases, also underscored the value and cost-effectiveness of health promotion, early detection, and linkages with other community social and educational systems. Our report documented the often inappropriate and more costly use of hospital emergency rooms, owing to either a lack of insurance, unavailability of community based primary care services, or both in impoverished inner city communities. Approximately 6% of hospital admissions in these communities would have been unnecessary had there been adequate primary care and ambulatory care programs readily available. Long term care facilities serving our Medicaid populations throughout the Greater Philadelphia region are sorely lacking, causing longer hospital stays. Our study reflected a general lack of knowledge about the existence and availability of services in Delaware County. Only 30% of the children in the City of Chester are immunized and 33% of women over 40 in Delaware County had not received a mammogram in the past year. All of these problems are greatly magnified for our homeless population.

Mr. Chairman and members of the subcommittee, I cite all of this to underscore the importance of these hearings. Having legislated entitlement is not sufficient to assure access and availability to health care in our inner cities and urban areas. Two women a week dying unnecessarily of breast cancer in a community with at least ten mammography units, 70% of the low income children of the City of Chester beginning school with no immunization, AIDS spreading rapidly beyond the drug abusers and into the high schools of our middle class communities and low birth weight and total lack of prenatal care in the face of free community based services are the result of people needing care that is available but somehow not getting that care. If all we do in this time of reform is pass universal entitlement, if we honestly believe that a single payor system, or any other form of payment system will overcome the problems of access and availability of care, we have lost opportunity for real reform--for really making a difference in our communities. What is needed is a total re-structuring of our health delivery system and the payment systems that must support our vision.

What we need are accountable community health networks, that are at reasonable risk for the health status of the populations they serve and that have the latitude to re-direct resources towards greater emphasis on outreach early detection, prevention and health monitoring. Payment systems should be a tool of our achievement and not the focus of our reform debate. If we want a healthier society, then payment should be population-based with a defined benefit package. Today our payment systems are tied to illness with no incentive, and, in fact, they often act as a disincentive to keeping people well.

To redirect our efforts to keeping people well and out of our hospitals and costly emergency rooms will also require reasonable time and resources to assist in this conversion. And we will need to bring the ultimate beneficiary of health care on to the health care team through education, outreach and incentives that make healthy lifestyles more important to each of us. As Pogo said, "We have met the enemy and they are us."

In response to our community health needs assessment findings we have organized a county-wide Women's and Child Health Initiative, partially funded with local corporate contributions. We have instituted two additional Women's, Infants and Children (WIC) and Maternal and Infant Care (MIC) Centers, a Behavioral Medicine Institute through which the clinical services of our over 30 psychiatrists and social workers can be better targeted, and a Senior Wellness Institute to address the special and growing needs of our elderly population.

Our primary care physician network, Health Access, and our recent decision to expand our Family Practice residency are further initiatives taken in response to our Community Health Needs Assessment. Each of these practice sites, which were selected based on an in depth Primary Care Physicians Needs Assessment, participate in the Pennsylvania Medicaid risk contract, as well as participate in other major managed care programs operating in the Greater Philadelphia community.

It is in response to your Committee's interest in access and availability of care in our urban and rural communities that I outlined the formation, structure and vision of Crozer-Keystone Health System, and the impact of our indepth Community Health Needs Assessment. We believe these efforts and those that flow from them will improve access and availability of cost-effective care, without a large and additionally expensive government bureaucracy. Health care reform is already well underway throughout our country through the formation of community health networks such as ours.

To achieve health care reform and assure greater access and availability of care to every American could be greatly aided by government action to encourage and support more health promotion and personal health responsibility, more appropriate reimbursement for ambulatory care, home care and population based health screening. A vexing and costly problem is that of excess and/or inappropriate capacity, particularly in our inner city communities. Assistance to enable the closing of unneeded acute hospital facilities or to assist in their conversion to more needed long term care facilities or as community ambulatory and diagnostic centers would be most welcomed and appropriate. One might think of it as reverse a Hill-Burton program. It is most difficult to close or convert a voluntary community hospital that no longer can or needs to serve the inpatient needs of a community without direct government support.

Local community health networks, with local consumer and provider representatives, are ideally suited to negotiate these trade-offs.

And lastly, we need immediate relief from costly and counterproductive antitrust actions brought by those who want to resist consolidation and system reform. Since 1984, just ten years, I have personally represented my institution in no less than four major antitrust actions. They ranged from a charge of unfair competition by a group of cardiologists denied cardiac catheterization privileges to our most recent suit brought by a solo provider of home care services against a community based, former VNA, home health agency formed to ensure its survival by five community hospitals. It was the only not-for-profit home health agency serving our poorer inner city communities but the charge by our for-profit litigant was that he had an unfair competitive disadvantage. None of these antitrust cases ever went to trial and each took anywhere from two to five years to finally settle out of court. In each case the mounting cost of defense and the organizational disruption brought on by endless discovery finally made a negotiated out-of-court settlement the more prudent course of action. Millions of dollars were drained out of our community health system needlessly by these frivolous actions. If health care reform is to ever succeed, local providers need relief from these sorts of counterproductive actions. We need laws that encourage collaboration and community values not competitive advantage.

Because we are a seamless continuum of facilities, services and resources, Crozer-Keystone has already begun planning for the conversion of two of our present acute inpatient facilities to a major community Wellness and Fitness Center and in the other case a comprehensive Community Ambulatory Care and Diagnostic Center targeted to serve the specific needs of a large disadvantaged community. Inpatient acute care, specialty and tertiary services will be linked through a recently installed 47 mile fiber optic network that ties our system together as a seamless continuum. A Lifetime Clinical Record will become a reality for the patients of Crozer-Keystone by 1995, providing the

patients and their care gives a lifetime longitudinal record of their health services and health status.

Health care reform, whether voluntary or governmental assisted will need to invest significant new dollars into building information and communications networks that allow the community health networks of tomorrow to communicate, transmit data and images and to collect and assess health and cost data necessary to establish and track health status of a defined population. Greater investment will need to be made in outcomes measurement and community accountability. Only then can we share expensive technology, provide broad geographic access to specialty care and begin to eliminate costly duplication and excess capacity. While these investments will ultimately more than pay for themselves they will require initial subsidy support.

As community health networks similar to Crozer-Keystone develop, linked together with appropriate telecommunications and information systems, serving at-risk large defined populations, emphasis will quickly shift from an orientation toward illness and cure to that of health promotion and health status improvement. Questions of access and availability of care will be dominant concerns of our community health networks, who will be a economic risk when someone falls through the cracks. It will force a new interactions & partnerships between providers and their patients to know what services are available in their community, how and where to access these services and a warning light when appropriate care is not sought. Only then can we say that we are in the business of health, the health of the communities we serve.

Thank you for the opportunity to share these thoughts on health reform and the importance of timely and appropriate access and availability to cost-effective health care. I congratulate you and your committee for these hearings.

Chairman STARK. I have a concern. Mr. Cook, I think that on page 4 of your statement you raise the issue of providing health care to undocumented workers or illegal immigrants or tourists. And you see this as a Federal responsibility and I wholeheartedly agree, although I am not sure that I am in the majority on that position.

Now, while some believe we should limit health care to cover citizens only, would you agree that in fact if we do not include all residents in a plan, that we are still going to pay the cost of treating these people one way or another, either through local taxes or public facilities, through cost shifting to insured patients?

Mr. COOK. The mission of our corporation says that we have to provide services to all New York City residents regardless of their ability to pay, and we do not even have a mechanism for determining a person's legal residency in this country, and I don't think doctors that are concerned about stabilizing sick patients have the time to do that.

So those patients will still get care. The question is how will they be paid for. Today the payment, the uncompensated cost for providing care to undocumented patients, is covered on a local level and not covered enough.

I think my corporation has uncompensated costs approaching \$300 million that have to be subsidized by the city and the State, primarily by the city, and that has a detrimental impact on the care that we provide to those Medicaid eligible and Medicare eligible patients in that there has to be some cost shifting.

We think that if this is dealt with, the overall system will improve in New York City at least.

Chairman STARK. Do any of the other witnesses strenuously disagree with that position?

Ms. ROTHSTEIN. No, not at all.

Mr. McMEEKIN. No, sir, and we are a community in Philadelphia that does not have a public hospital, so that burden, which I think is appropriate to meet, often falls on the voluntary hospital system in the absence of a public hospital.

Chairman STARK. The next issue is of two parts. Ms. Rothstein states that the problem of two out of three children in Milwaukee hospitalized for measles were enrolled in a managed care plan, and we of course have heard the clarion call of how great managed care and competition is.

That indicates to me some failure by these managed care people with these deep and abiding social concerns to get around to immunizing patients under their care, and there is talk in some health care reform proposals that health plans will compete. You know about competition in Chicago.

That means getting to the other end of the court in a big hurry. Do you believe, Ms. Rothstein, that the managed care types of programs that you are familiar with are going to get in there and compete in Chicago for your Medicaid beneficiaries and for your uninsured or low income people?

Ms. ROTHSTEIN. I have a real problem. I have spent 25 years as the president of a private hospital, Mount Sinai Hospital of Chicago. Mount Sinai Hospital of Chicago, as our board was wanting to say, is a private hospital doing the work of the public sector.

The patients that Mount Sinai takes care of today are the same patients that I take care of today at Cook County Hospital. I have a personal proclivity. I really don't believe that the patients that we take care of are seriously going to be taken care of in a managed care or competitive environment.

I personally believe in, and I was for and have always been for, a single-payer system and I still am. I am, however, willing to take a shot at managed competition, if I have to, because something has to give. I think everyone is expecting and looking forward to having some kind of a plan put into effect in the next year or two.

If we do not do that, our current fragmented system will become more unraveled. I truly believe that our patients will fall through the cracks. If we are not adequately funded, they would not be our patients, because we could close. They are the citizens of this country, and that is the real issue.

We call them our patients. Not true. They are citizens of this country.

Chairman STARK. Let me try one last item, and you will hear it here first, but I am concerned because in California, our Governor has attempted to take part of our Medicaid population and bid it out to managed competition, leaving parts of it with counties that in many cases run the Medicaid program in California. I have been aware of some risk selection, and selective marketing by those plans, and it occurs to me that in general the way we pay for Medicaid is an uncapped system.

I imagine you have 400,000 people on Medicaid in Cook County. I have 100,000 people. If I sign them up one way or another, I start to get paid the day I sign them up. Is that not correct?

Ms. ROTHSTEIN. Correct.

Chairman STARK. What if we said, uh-uh, you don't get paid the day you sign them up. You get paid the day you bring in a jacket that shows a health history and shows that they have been immunized and at least you have their blood pressure and whatever the physician community would say is enough information about that person to know whether or not they should be flagged for possibly developing diabetes or possibly being pregnant or possibly a child not immunized, and then we will pay you.

And then the jacket is in the professional arena where they can't say they never came to see me, and therefore there would be no malpractice or suggestion of shortchanging these patients because they didn't get treated. To get paid, you have got to get them into the system. Would a change in the way we reimburse, something along that line, begin to get more attention for these people we sign up in capitated plans?

Ms. ROTHSTEIN. I don't know. I really don't know that I could answer that. Yes, I could be glib about it and say, well, there are all kinds of ways that one needs to look at how we pay, how we select, how we choose, what kind of systems we are going to look at.

I think it is tinkering. Again, it is tinkering and I think that it is time for all of us to stop tinkering. Would it be better if we had a system whereby all outpatient services were connected and linked together between the city and the counties and the private sector?

Yes, I think that is very important, and I think we need to be looking forward to doing that. But I still think we need to have something that we anchor, and the something that we anchor is a system of delivery of care that talks to everybody in the same way, whether it is me, whether it is you, Chairman Stark, or whether it is a Medicaid patient. We need to talk the same language to everybody.

Chairman STARK. Mr. McMeekin.

Mr. McMEEKIN. Mr. Chairman, I like your idea. We happen to contract with four Medicaid risk insurers in our part of Pennsylvania and what is clear is that the whole focus or approach to health care shifts for those persons where there is truly an incentive, first, to get to know them, to get to know early on in that relationship what health problems they have, and to begin trying to preclude some of the health problems that traditionally we see. As my remark suggests, it changes the focus from taking care of sick people to really trying to keep people well and I guess I have no apologies.

It also has a very important financial incentive that if you are successful at doing that as providers, doctor, hospital, you are paid more adequately under Medicaid. In fact, quite adequately under that program as compared to taking care of the sick when it is so desperate and very expensive. I think that begins to shift our focus.

I also think there has been dramatic evidence of being able to self-select in our managed care populations and deal with only the young and the well and leave the older and the more sick for the traditional programs, and I do fear that if we are not careful in our quest for a managed competition environment where it is left totally to the marketing skills of any one organization, we are going to see a lot of that.

I much prefer having some way of assigning populations to a provider network, a community health network or whatever that says, you are responsible for these people, well and sick, and the opportunity is to keep them well.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Mr. McMeekin, I just wanted to ask you about your community needs assessment. Regarding the low rate of immunization among children in Delaware County, you say in your testimony, our study reflected a general lack of knowledge about the existence and availability of services in Delaware County.

Why is that? And I assume we are talking for the most part about low-income individuals; is that correct, in terms of the immunization rate?

Mr. McMEEKIN. Congressman, if I may, let me quickly describe Delaware County. It is fairly large, one of the five counties that make up Greater Philadelphia, a very urban county, probably middle to upper middle class in most parts of the county. It does have that one very significant pocket of poverty called the city of Chester.

The study looked at all 550,000 people so it was probably looking more at the middle and upper middle class communities than it was just at the City of Chester. The lack of information or at least the stated lack of information was countywide.

Likewise, problems of low birth weight are clearly more evident in the city of Chester, in the poorer communities, but I guess what

astounded me was the fact that that is where we have such concentrations of those services today under the WIC program, maternal infant care and the like.

Somehow we are putting a lot of resources in place but we are not communicating or allowing people to access them or know about them or know how to——

Mr. GRANDY. That the major cause, in your view, for the low rate of immunization is the public outreach or lack thereof?

Mr. McMEEKIN. No, but I think one of the major solutions to reducing that problem would be to have more proactive, actually more incentive to go out and find those young mothers and their children that are not availing themselves of those services.

I think a lot of it is just the social fabric or the lack of a social fabric in some of our lower income communities, but nonetheless, I think if we don't attack it, don't more aggressively seek out those who do need the services, and as providers take responsibility and be at risk for that, we will never, never get over that mountain that is just growing.

Mr. GRANDY. Go ahead. I am sorry.

Mr. McMEEKIN. What I found astounding about our study is, in the shadow of six medical schools in the city of Philadelphia as a middle class community, we have just very, very discouraging health statistics and health status.

Mr. GRANDY. And what you are talking about is the discouraging statistic of people not seeking care which is available to them?

Mr. McMEEKIN. Right.

Mr. GRANDY. Am I correct in concluding that?

Mr. McMEEKIN. Yes, sir.

Mr. GRANDY. Because you are not alone in this. I represent Woodbury County, Iowa, the major population center is Sioux City and they only have a 48 percent immunization rate there because of very similar kinds of populations, most of them due to an emerging Hispanic and Southeast Asian population which now constitute a lot of the folks that would be otherwise getting immunized.

What suggestions do you have for us in trying to expand or modify our immunization efforts at the Federal level right now?

Mr. McMEEKIN. Well, I think, again, to just, as Chairman Stark's hearing suggested today, to just put more entitlement money, support, into those programs without getting people to carry them out to those who need them or those people who need them to avail themselves of it is not going to reduce the problem.

It is sort of like taking an aspirin when you are sick. It may make you feel better but it may not do much for the cure. I think we need to just have more structured delivery systems that have as part and parcel of their being responsibility for that community, and I think when we move to that, we are, one, moving away from just illness and looking at immunization and health promotion, and, two, you start focusing responsibility, without quibbling a bit with Ms. Rothstein's earlier comment about Cook County Hospital and who those patients belong to. I do understand her point.

I would make a different point. I think when we have developed those accountable health partnerships, community health networks, whatever they might be called, they will feel an accountabil-

ity for that population, whether it is a geographical or contractual population in a different way than hospitals and doctors do today.

Today the only people you are responsible for are the ones who walk through your door, and most of those are lawyers that are in there for some other reason.

Mr. GRANDY. What I am not hearing you say is that there is some tie to the low rate of immunization. I assume in most cases you are talking about preschool children, kids that have either not gotten into a Head Start program or any kind of preschool program.

Mr. McMEEKIN. Yes, sir.

Mr. GRANDY. You have not mentioned that there is any nexus between that and the price of the pharmaceutical which has been the subject of some debate in this committee and others.

Mr. McMEEKIN. It is clearly a concern to the provider community because we often find that we are involved in programs, as we are right now with hepatitis and influenza in Delaware County, where we are providing free immunization and the cost of that immunization is not at all insignificant.

We have turned to the corporate community and looked for their help. But I don't think that is what is causing the problem in our inner city of Chester which I am familiar with.

Mr. GRANDY. In most cases the pharmaceuticals you would be providing would be free, would they not?

Mr. McMEEKIN. Yes.

Mr. GRANDY. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

First of all, let me thank each of you, not only for your testimony for the committee, but for the work that you are doing to provide care and access to people who otherwise would go without services.

You have done a tremendous service to our country under extremely difficult circumstances and funding. I am, though, somewhat troubled by some of your testimony. I agree with the major thrust that health care reform and even universal access to care through universal coverage does not guarantee that every person, particularly the people that you are serving, will receive adequate care, and we need to make sure that that is part of health care reform.

But I am troubled by some of your testimony as it relates to the future of public safety net hospitals. I should tell you, I come from a congressional district that has two former public safety net hospitals. We changed the status of those facilities, not because we didn't agree with their mission. We agreed with their mission. We think that we made it more effective.

The Baltimore City Hospital, which is now part of the Johns Hopkins Hospital family, used to be owned and operated by Baltimore City. Our university hospital which was budgeted through our State is now a private facility and has perhaps one of the most ambitious capital expansion programs of any medical facility in our State.

We have been able to take publicly supported facilities and make them private and still carry out their mission, although Maryland under a current system has been able to build an all-payer rate

system so that uncompensated care is paid for by all payers, and we don't have the problems that you have with the large numbers of people who come into your facilities that do not have anyone paying their bills and it is not shared.

As we go to a system that will provide universal coverage so that we can get rid of the problems that you currently face with uncompensated care, and if we can deal with the teaching cost and some of the other provisions, I question the need for public safety net facilities in the future.

I am concerned that as I look at public hospitals, I look at the age of the facilities generally and they are much, much older than the private facilities. I think Cook County's facilities probably share a national record—85 years, if I remember correctly. Many, many years ago there were recommendations to close that facility.

I also am concerned by the mission of safety net public hospitals as to why they shouldn't be broader missions, and in Baltimore again, the former Baltimore City Hospital is known throughout our State as providing the best care for burn victims.

So it is not just looked at as a charity hospital or a hospital of last resort. It has a primary mission, as does our university hospital have primary missions within our health care system. I am also concerned about the stigma of public safety net facilities and why should people go to a facility that has that stigma.

Does that not create different levels of care in our society?

So although I am very much encouraged by your commitment and your strength in dealing with very difficult problems, I would appreciate your views as to whether we and the health care system of the future that we craft would need to have public hospital facilities.

Ms. ROTHSTEIN. Can I try to take a crack at that? I have a similar worry, and I am concerned. I have thought about this a whole lot because we face in Cook County the need to replace Cook County Hospital. It was never supposed to be closed. It was supposed to be rebuilt years ago. It never got rebuilt.

As I said I have given this a great deal of thought because there is a concern of how do we raise the funds for this new facility. What is it? What kind of facility do we want? How large should this footprint be? What is it we are going to deliver in care?

And I have thought about it, talked about it, mused about it, and I have come to the conclusion that in the next decade or more, the need for public institutions will continue to be imperative. One reason I say this relates to your comment about a State university. We have a State university that is just two blocks away from Cook County Hospital.

Yet, in my judgment, and you are right, while for financing it feeds at the public trough, its mission is private.

Mr. CARDIN. Our university hospital ran at a huge deficit when its hospital care budget was on the State budget. It is now a private budget and it is running at a healthy profit. The people who utilize that facility have not changed.

It is an inner-city facility in which it has a large percentage of uncompensated care and some of the most difficult patients in our State.

Ms. ROTHSTEIN. I come from an institution where the level of type of patients are very similar to the public hospital system as I said earlier. We probably break even because we run a very tight shop. We run a very difficult institution. There is no fat available.

You can't go in there and say, well, we will squeeze out the fat. There isn't any. I think the public hospital system also is beginning to learn that they need to rethink, restructure, and reframe not only how you run an institution, but to change the method in which they deliver care.

I don't believe that the public hospital system needs to be the hospital of last resort. We deliver the kind of care that I believe other hospitals can't deliver or won't deliver or are not interested in delivering.

Mr. CARDIN. They are not interested in many cases because it is uncompensated. They are looking at the bottom line.

Ms. ROTHSTEIN. I have thought about this a whole lot as well, Congressman. I am not sure even if it were compensated decently that a private hospital on the Gold Coast of Chicago would be interested in dealing with the tuberculosis patients, would be interested in dealing with AIDS, would be interested in dealing with cocaine babies to the extent that the public health system deals with this.

I think in no way can we abandon public hospitals in this country. This is a very personal opinion. I really feel that the public health system in this country, if we do not support it, will indeed create many more problems for us as we enter into the 21st century, and I really believe that it has to remain strong. It doesn't have to be as big.

I mean, there is no need for a Cook County Hospital with a 918 bed capacity. There is a need for a 450 bed tertiary care facility that deals with the very sickest of our society.

Mr. COOK. May I comment regarding New York City?

Mr. CARDIN. Sure.

Mr. COOK. I think the Health and Hospitals Corp. is, I said before, the largest municipal hospital system in the country. It is the largest health care provider in the City of New York, where I am sure everyone knows New York City and the Northeast has the highest concentration of health care providers in the country.

So by virtue of our geographic location, we do compete with a lot of the voluntary hospitals in the city of New York. Bellevue Hospital Center is right next to New York Hospital Center, a tertiary hospital for New York University and competes very well with them.

Given the size, the magnitude of our system, there are those facilities that compete very well with voluntary hospitals and then those facilities that are challenges. I might also add that we have to serve—so we compete in those areas where we need to compete, and then some. We have to serve everyone. Our mission is very broad.

We have to serve those people, those patients that live in areas where there are not services that are provided. The question is what sort of incentives can be instilled in national health care reform that will convince those other facilities to go to those economically distressed areas. I think, as the Congressman said earlier, the

jury is still out on that, and in the absence of that, this corporation will still be providing health care services in those areas.

Mr. CARDIN. There is a vote on, as you all know. We will need to take a very short recess. We expect that we will reconvene within 5 minutes.

[Recess.]

Chairman STARK. I am sorry to hold the witnesses as we try and get through these votes. Our vote schedule today is a little random and we appreciate your participation. Your comments and your expertise in this area, the support for my bill notwithstanding, are appreciated, and I do hope that we can continue to receive your counsel as we go through this issue of reform which will be, I think, somewhat longer and more complicated than any of us at this point imagine. But I think everybody is dedicated to seeing that we stick to it this time and get it done.

So we will be looking forward to working with you over the—I hope it is only months, but it may be even the years ahead. Thanks a lot.

Our next panel of witnesses are directors of community health centers. They are Greg Nycz, the project director of the Marshfield Medical Foundation in Marshfield, Wis., Cornell Scott, the executive director of the Hill Health Center in New Haven, Conn., and John Silva, the executive director of the Family Care Center of Carondelet in St. Louis, Mo.

I would like to ask the witnesses to make themselves comfortable at the table. Is Nycz the correct pronunciation?

Mr. NYCZ. I have to say you are only the third person in my life who has pronounced that correctly if you haven't been coached.

Chairman STARK. I have been coached. Is the Marshfield Medical Foundation what I would refer to as the Dagee Clinic?

Mr. NYCZ. Yes, it is. It is. It is actually Marshfield Clinic.

Chairman STARK. Is any of the Dagee family still connected with it?

Mr. NYCZ. They are no longer practicing but they are—

Chairman STARK. There was a son who didn't practice who would be 70 today.

Mr. NYCZ. The building that we occupied as a research foundation at one point was the old Dagee Clinic which was across from the hospital many years ago.

Chairman STARK. I grew up summers in Forest County next door to Dr. Dagee so that goes back a long way. Why don't you proceed, Mr. Nycz, to lead off and then we will hear from your colleagues at the witness table in the order that we called their name.

STATEMENT OF GREGORY R. NYCZ, DIRECTOR, FAMILY HEALTH CENTER OF MARSHFIELD, INC., MARSHFIELD, WIS.

Mr. NYCZ. Thank you. I must say this is the first opportunity I have had to testify before Congress and any anxiety that I may have felt quickly evaporated when I heard your opening statement and the initial questions.

I am really excited about the sense of interest that has been expressed not just from yourself, but from the other subcommittee members on this topic. While what we have just heard from the hospitals stresses the tertiary side of the health care spectrum, our

focus will be on the prevention and primary care side, and on a targeted approach to reach underserved, low-income populations.

I have struggled with exactly how I should approach this testimony and one of the things I would like to do is begin with an example. I want to encourage you to invest in health centers and, while I represent a rural perspective, one of the things I like most about the health center movement is that it isn't rural, it isn't urban, it isn't any particular race, any particular age. We are concerned about people in need of care and we are concerned about getting services to them.

As an example in Wood County, we have Marshfield Clinic. Through the clinic our health center reaches out about 7,000 square miles to bring health care to small rural communities. Within Wood County we also have a public health agency. We both provide health check screens to children in Wisconsin through the EPSDT or periodic screening for low-income children on medical assistance.

For many years, Wisconsin and Wood County have had extremely low rates of EPSDT screening. This occurred although these children have an insurance mechanism through the medical assistance program and in spite of the fact that they have access to providers through the public health department and through the Marshfield Clinic, and in spite of funding for outreach. The outreach is funded by the State of Wisconsin which uses its data system on the medical assistance program to identify children who haven't had periodic screenings and are in need of them. They provide that information to the public health department and ask them to conduct outreach to these individuals and get them in for care.

For many years, in spite of the capacity, in spite of the insurance and the presence of outreach, we failed in getting many of these children screened. The capacity in the health department was limited and we weren't talking to each other. One of the exciting developments of even the threat or the discussions of health care reform, is that it is forcing folks in the rural communities to start to come together and to work together on common problems.

Marshfield Clinic is hearing from a growing number of small group practices and physicians. Some are aging, out of practice, and after serving rural communities for 20 and 30 years worry that when they leave, there will be nobody there to replace them. They are coming and talking and saying, can we become part of your group, and in so doing, harness some of the recruiting and retention powers of a larger system of care.

As a result, Marshfield Clinic is growing. The clinic now has 400 physicians, 300 of whom practice in Marshfield and more than 100 that practice in 23 regional centers.

With health check screenings, what has happened is we sat down with the public health agency. We said, our collective objective is to get these kids off to a good start. How do we do that together? We developed a system by working together where the health department outreach worker gets the individual on the phone to facilitate an appointment. They can tie in with our appointment secretary, directly referring to our system.

We have managed to triple the number of children being screened as a result of that system. I think there are a number of lessons in that example for health reform. In spite of having insurance, providers and outreach, we still need to look at what causes people, at least on the preventive side, not to obtain those services. We need to make investments in research to help us with that.

I am not sure whether anybody will be speaking about the migrant population today, and I don't want to overlook the migrant population. In Wisconsin we serve upstream migrants. They are there for a short period of time during the summer. They come into the State to trim our Christmas trees, to pick our vegetables and to work in our canneries, and we have only one migrant health center in the State that serves their needs through a clinic system.

There are two models. One model is based on vouchers where migrants are given a voucher and allowed to go to local providers who will honor the voucher. One of the things that is very difficult for migrants under this system is that having the voucher isn't enough. They are in Wisconsin to work and if they don't work, they don't feed their families later on, and so hours of operation become critical.

Bilingual staff become critical, and transportation becomes critical. I really would like to urge you to maintain culturally responsive clinical services rather than moving to a system that just gives them a card and asks that they fend for themselves. It is not going to be culturally responsive care.

[The prepared statement follows:]

**STATEMENT OF GREGORY R. NYCZ
DIRECTOR, FAMILY HEALTH CENTER OF MARSHFIELD, INC.**

**SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

**Hearing on Health Care Service Delivery Infrastructure in Inner City
and Rural Communities**

June 24, 1993

Chairman Stark and members of the subcommittee: I am pleased to have the opportunity to provide this testimony on primary care and preventive service delivery issues in rural communities. I am speaking as the Director of Family Health Center of Marshfield, a community health center that has been serving low-income and uninsured residents throughout 7,000 square miles of rural central and northern Wisconsin for over 20 years. Our partnership with the federal government through the community health center program has helped to bring comprehensive primary health care and preventive services to tens of thousands of low-income residents of northcentral Wisconsin.

As the country seeks to fundamentally reform our nation's health care system, it is deeply gratifying to know that your subcommittee recognizes that, for millions of Americans, simply having an insurance card is not sufficient to guarantee access to needed health care. My experience in Wisconsin has convinced me that we must make investments in service delivery systems that can provide truly accessible, culturally-sensitive health care to medically-underserved and hard-to-reach people in rural areas and inner cities. I offer comments, which follow, in the hope that they will be helpful to you as you formulate policies that will make the promise of health reform a reality for all Americans by strengthening the primary care delivery system in rural areas and inner cities.

My comments will focus on four broad issues that will affect the ability of community health centers to provide primary care to the under-served. First, medical educators must be encouraged to train more primary care providers willing to practice in underserved communities. Second, the "managed competition" approach to financing must be sufficiently flexible to allow and support network formation and "managed cooperation" in areas without adequate providers or infrastructure. Third, special resources must be made available for "adaptive services," such as translation and outreach, that help reduce the barriers to care which underserved people face. Finally, we must be willing to invest in community-based research to identify effective and efficient means of delivering quality care in our most difficult-to-reach communities. We must make strategic and ongoing investments in each of these areas if we are to capitalize on the potential for primary care and preventive services to improve the health of all Americans. I will conclude with a few brief comments on administration and financing.

MEDICAL EDUCATION

There seems to be general consensus that we must change our approach to medical education to train more primary care practitioners and proportionately fewer specialists. I would urge the subcommittee to augment those reforms with specific steps that would increase the primary care practitioner work force with a sensitivity to the needs of underserved and minority populations. Reforms should strive to train more practitioners who are likely to practice in underserved communities and who will provide services in a culturally sensitive manner. With the demand for primary care practitioners increasing with the growth of managed care, even a substantially increased supply will not eliminate recruitment and retention problems which isolated rural and urban inner city communities face. Specifically, we must continue to build on programs designed to address the geographic maldistribution of health professionals and promote interdisciplinary team approaches to service delivery. Given these needs, it was particularly distressing to hear that funding for the Area Health Education Center program was targeted for a severe cut and funding for interdisciplinary health training grants was targeted to be eliminated.

As a group, health centers struggle continuously with the difficulties of recruitment and retention of scarce primary care professionals. In Wisconsin, health center representatives have become very involved in the development and operation of a federally-funded Area Health Education Center. We are working with the medical schools and the State to assist the educational system in becoming more responsive to local community needs. In rural Wisconsin, we have developed an interdisciplinary training center at one of our community health centers. The comments of a pharmacy student from Madison who trained at the center suggest that such educational experiences can be wonderful recruitment tools. The student, commenting to the local hospital administrator, said that his experience was not what he had expected from "backwoods medicine" and that he would definitely consider employment at their hospital. Similar experiences help to establish local support for off-campus educational experiences in rural locations.

Health centers and other organizations serving medically underserved populations need assistance and encouragement to develop graduate and undergraduate training opportunities for the next generation of clinicians. We must find support to train health center clinicians as educators and to support them in their teaching activities; and we must ensure that qualified health centers can fully participate in, and even directly conduct, health professions training at their community-based sites.

NETWORK FORMATION

On March 10-12, 1993, I had an opportunity to attend a conference entitled "Health Care Reform in Rural Areas". The conference was held in Little Rock, Arkansas and was jointly sponsored by the Robert Wood Johnson Foundation and the Arkansas Department of Health. While stressing flexibility and a range of options for rural areas, the conference focused on the development of regional health care networks in rural areas. The group reached consensus that the local provision of primary and preventive care services should be a priority under health reform and that "rural health networks have the potential for improving access to needed services, utilizing resources more efficiently, and strengthening the practice of medicine in rural areas."¹ Our experience at Marshfield Clinic illustrates the potential regionalized systems of care have for meeting the needs of isolated rural community residents. Marshfield Clinic is a 400 physician, 2500 employee, 77 year old multi-specialty group practice with 22 Regional Centers, 18 of which provide primary care services to existing communities with populations ranging from 830 to 12,400. In partnership with the health center Marshfield Clinic not only has recruited and retained physicians and other health care practitioners in smaller isolated communities, but has also successfully reached out to low income individuals and families throughout the area and integrated them into a system of care. Marshfield Clinic has invested capital in modern facilities which enhances recruitment and retention and builds local pride in the community's health care system. The result is maintenance of services closer to people in need, a key feature in improving access in rural communities.

The existing health centers - together with a number of other "safety net" providers (other community clinics, comprehensive local public health clinics, rural and disproportionate share hospitals, and the few independent physicians practicing there) - form the backbone of the local health care system for most underserved people and communities, both rural and urban. They need direct assistance and support to link with each other to form Community Health Networks (CHNs) focused on serving the people living there; and these networks will need to be appropriately recognized as managed care systems under health care reform. Moreover, current federal laws and policies which pose barriers to Network development (such as restrictive budgeting requirements and "fraud and abuse" limitations) will need to be amended to permit appropriate linkages that benefit underserved people and communities.

Once established, the networks will need both recognition and special reimbursement requirements that:

- Assure that they and health centers are fully included in all managed care arrangements serving (or proposing to serve) local underserved communities and populations.
- Assure adequate payment rates and stop-loss coverage to the Networks and health centers to promote their mission, recognize the complex needs and mix of patients they serve, and protect their solvency.

As an advocate for underserved populations, I believe it is critically important to encourage collaboration and the development of networks in the broadest possible sense. We have been more successful in achieving the goal of access to comprehensive primary care and preventive services for all in our community when we work and cooperate with others who have similar priorities and target populations. A local example illustrates this point. In spite of the fact that Wisconsin has a relatively generous Medicaid program, Wisconsin's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) rates have been very low. The purpose of EPSDT is to help children get off to a good start through regular preventive health visits and screening services and appropriate follow-up on problems detected through screening. To improve compliance with recommended EPSDT screening in Wisconsin, the State generates "targeted lists" of children in need of screening and periodically forwards those lists to local county health departments. For years, one local county health department in our area used these lists to generate appointments for its own EPSDT screening program. However, because the county's clinical capacity is relatively limited, the full potential of the targeted lists was not realized. As a community health center we were also interested in improving EPSDT screening rates and jointly applied with the health department to become a demonstration project under a program sponsored by the National Association of County Health Officials.

To realize the potential of the demonstration project, we had to overcome the perception that we were "competing" for Medicaid patients and focus instead on cooperating to maximize the number of children screened. We also had to develop financial sharing arrangements since under the terms of the EPSDT Program in Wisconsin, outreach and case management associated with EPSDT screens are reimbursable to the county health agency. We met both challenges successfully. Under the project, we tripled the monthly number of health check screenings for county residents at our health center and enhanced the health department's outreach effort by enabling them to receive the outreach fee for their referrals. The system we implemented allows the county outreach worker to establish a three-way telephone link with our appointment secretaries and the medical assistance recipient for scheduling a screen. We would like to expand this approach to improve mammography and pap testing for Medicaid recipients, but rules governing patient confidentiality have been interpreted as prohibiting this approach.

A major advantage of integrated service networks, Accountable Health Plans, or HMOs is the opportunity for improved data systems. When all the care an individual receives is in the system, health providers can discern which preventive services are needed by patients in the system. Health reform must produce a delivery system that captures such data. However, although a comprehensive data system may be a necessary component in the effective delivery of primary and preventive health services, it is not sufficient to ensure comprehensive care, as demonstrated by the measles outbreak in Milwaukee several years ago. Extremely low rates of childhood immunization existed among Medicaid-eligible children in spite of the fact that virtually all of these children were enrolled in HMOs.

In addition to developing better data systems, health reform must require accountability for the delivery of preventive services. There is considerable anxiety among many publicly-funded health systems over their ability to compete based on as-yet defined standards of "cost" and "quality". Organizations such as health centers have been in the trenches delivering primary and preventive services to difficult to reach populations for more than two decades. Health centers success in the provision of primary and preventive services to underserved populations will not go unnoticed by larger health care concerns if such "accountable health partnerships" are required to routinely report on primary care delivery

measures such as immunization rates, percentage of women receiving prenatal care in the first trimester, and the percentage of patients receiving recommended health screenings, as health centers are required to report on today. While there has been debate over the meaning of published hospital mortality statistics, there should be little confusion over the meaning or implications of low immunizations levels. I believe that such measures would help to increase preventive services for all and assure that health centers and other entities now serving medically underserved populations will continue to be recognized and valued for their contributions to community health. Such accountability will also engender greater support for continued funding of special or adaptive services.

ADAPTIVE SERVICES

Health centers have learned that they can not be successful in increasing utilization of primary and preventive care services without the capacity to reach out to special populations, such as farm workers, homeless persons, recent immigrants, frail elderly and isolated rural residents. In some instances, this might mean offering extended hours of operation, which is particularly important to migrant farm workers and other low-wage earners for whom a trip to the doctor might also mean a day without pay. In other instances, it may mean establishing and staffing clinics in an isolated rural community or utilizing mobile technology to bring services to isolated communities or migrant worker camps. For recent immigrants, and upstream migrant farm workers, access to translation services becomes critically important when bilingual health professionals are simply not available. In many instances such efforts are either not reimbursed or not adequately reimbursed. Transportation can be a significant barrier for frail elderly and low income populations in rural regions lacking public transportation. Public education and outreach efforts are critical to achieve increased compliance with screening and other preventive service recommendations. Because most Americans do not need such adaptive services, the services are unlikely to be included in a basic benefit package. However, targeting support for such activities is critical if we are to meet the health care needs of our nation's most vulnerable residents in a cost-effective manner.

COMMUNITY-BASED RESEARCH

While I strongly support the expansion of health centers as part of the nation's health service delivery infrastructure, and while I believe that health centers have an exceptional record in providing primary and preventive health services to difficult to reach populations, I must admit that we do not have all of the answers. If we are to achieve the goals set forth in Healthy People 2000, and eliminate some of the distressing variation in health status across many of our minority and disadvantaged populations, we must increase our support for community-based research efforts that can yield results that will directly assist delivery systems for the medically underserved. A recent experience at our Center illustrates this point.

A few years ago, the State of Wisconsin appropriated funds for a rural mobile mammography program. After reviewing county-level data, state planners determined that in 12 of Wisconsin's 72 counties, more than half of the women diagnosed with breast cancer had advanced disease at diagnosis. All 12 counties are nonmetropolitan. The State Division of Health contacted us for assistance in increasing breast cancer screening rates. We agreed to cover six of the twelve targeted counties. Early on we learned that there was very little in the research literature to provide guidance to our outreach staff on the most effective and efficient way to increase compliance with breast cancer screening in rural populations. Early participation was disappointing despite the fact that the screening was free for low-income women and partially-subsidized for those with limited means. Recognizing the critical need for information on how to effectively reach rural populations, we collaborated with the Wisconsin Division of Health on a research proposal to the National Cancer Institute. As a successful applicant, we are currently embarking on a number of researchable interventions in an effort to learn how to maximize screening rates. We view such studies as critically important, because they assist in identifying promising strategies which we can immediately

implement locally. Publication of results will assist other groups serving similar populations, as well.

It is important to encourage State agencies and researchers to reach out to health centers and other safety-net programs in an attempt to identify promising strategies to meet front-line problems in service delivery to medically underserved and minority populations.

In addition to investments in the above mentioned areas, I would urge Subcommittee members to consider the tremendous complexity embodied in our current health care system. This complexity can be found in regulations governing the provision of services and in increasingly complex rules related to the financing system. These regulations and rules are not just federal and state in nature, but also reflect differential approaches to reimbursement and service provision by multiple health plans, large employers, and other payors. Larger organizations like Marshfield Clinic employ professionals to help guide the provision of service through this ever-increasing complexity. What is difficult for Marshfield Clinic must be incredibly demanding for smaller organizations. From the perspective of low income residents, the complexity of programs designed to assist them is beyond comprehension. While most health centers have trained health benefits counselors and outstationed Medical Assistance workers to assist patients through this maze and to capitalize, to the extent possible, on existing programs, the complexity they face adds to the overhead and reduces precious service dollars. I ask, that as health reform progresses that you consider ways to cut overhead and maximize limited resources for direct service provision, also consider flexible approaches to finance service delivery to our nation's most vulnerable population, including, cost-based options for dealing with populations with special needs. Community health centers have proven that cost-based reimbursement systems need not be inherently inflationary nor administratively complex.

In summary, while there is more we can and should learn through community-based research efforts focused on underserved populations, federally-funded health centers and other community-based organizations have brought solutions to many of the problems associated with providing services to hard-to-reach populations and they have managed this accomplishment in an efficient and effective manner. We need more health centers and community-based networks, they need better financing, and we must work to assure that they have access to quality primary care practitioners through programs such as the National Health Service Corps and fundamental reforms in the medical education system. As the health care delivery system evolves and health reform shapes that evolution, there must be assurance that health centers evolve at the same time and that underserved communities maintain a voice and an opportunity to shape their health care delivery system. I ask that as you consider health reform you continue to build on your past support for health centers and for existing programs designed to address the geographic maldistribution of health care practitioners through programs like the National Health Service Corps and the Area Health Education Centers.

Footnotes

1. Health Care Reform in Rural Areas, Report of an Invitational Conference sponsored by the Robert Wood Johnson Foundation and Arkansas Department of Health, March 10-12, 1993.

Chairman STARK. If you will indulge me, off the record.

[Discussion off the record.]

Chairman STARK. Mr. Scott.

**STATEMENT OF CORNELL SCOTT, EXECUTIVE DIRECTOR,
HILL HEALTH CORP., NEW HAVEN, CONN.**

Mr. SCOTT. Yes, sir. Thank you, Mr. Chairman.

Let me start by thanking you for your ongoing support in our efforts at community health centers. We appreciate all that you continue to do on our behalf.

I am executive director of the Hill Health Corp. in New Haven. As you probably know, New Haven is a city of about 130,000 people, but the problems are of such a magnitude you would probably think it is one of the largest cities around the country. There is a high rate of poverty and all the associated problems that come with such high levels.

I would like to briefly highlight some points included in my written testimony. I will do this in a couple of ways. I want to discuss what we feel is an effective model for reaching urban underserved populations and rural populations. I think that you will find that we have a lot in common—urban and rural centers. While some of the problems are unique, I think we have been successful in addressing many of them.

I also would like to spend a little time talking about how we have responded to special needs, because herein lies the model, and conclude by speaking briefly on some of the challenges that we face.

First, let me describe what we have now come to think of as the traditional approach to making services accessible. We feel very strongly that there is a need for a multidisciplinary team approach. In light of the many problems that we face, substance abuse, AIDS, et cetera, no one person comes equipped to deal with all the problems, and so it is important that we utilize the skills of all providers and professionals in providing care.

It is important also that we hire staff who represent the ethnic and racial makeup of our patients, including those who are bilingual or speak whatever language is appropriate. We find that interpreters should be used as a last resort.

We also feel that it is important to address the transportation issues in conjunction with other agencies where appropriate and to provide child care for parents who bring their children to the center. We make sure that as many financial barriers are eliminated as possible. We utilize a case management approach to provide services, and this has been especially useful to us in serving the general assistance population which is the neediest of the populations we serve.

We feel that it is important to ensure that hours are convenient for the people who are at work or who are tied up during regular hours, when programs are normally open, and to make sure that there is around-the-clock coverage.

Another area that is extremely important is outreach. We have felt very strongly that patient pursuit and outreach is probably the most effective way to reach underserved people. People don't al-

ways take advantage of services because they don't know how to access them. So it is important that we do outreach.

It is important for our centers to pursue people who have been identified as needing special help. When we find a patient infected with tuberculosis, we follow up on medication compliance and coordinate care with family and friends.

It is important too that we create small centers, or satellites, in communities so that we keep services as close to the community as possible. In this sense, we have opened several satellites which have been very effective.

Now, in describing some of the new approaches that we have developed in responding to what I would term are special needs of the population, we have learned to maximize community and university ties. We have also strengthened internal systems.

The health problems that have been the most challenging to us have been AIDS and sexually transmitted diseases. We have responded in several ways. We are doing AIDS outreach to minorities and youth at risk. The youth program targets youngsters between the ages of 13 and 17 who are out of school.

We do a lot of HIV counseling and testing, not only in the centers, but in the community. We have an HIV case management component. This is a team that provides not only medical services, but social, mental health, and other services.

We have also developed a successful community program for clinical research on AIDS. This is extremely important because many individuals in our target population—women, minorities and injection drug users, have not had ready access to clinical trials. This program brings benefits directly to the community and is essential in taking away the mystique and fears that individuals in our communities have relating to research.

Substance abuse is another major problem. This was not a part of the mission of the center originally, but there has been an increase in the incidence of alcoholism. We have in operation a medical detoxification center, a 25-bed facility for the poorest of patients. They usually are chronic alcoholics who clog emergency rooms and drive up costs.

We also have an intermediate and long-term care, 44-bed shelter for homeless men, half of whom have substance abuse problems.

We provide outpatient treatment in one community for individuals suffering from alcoholism, and operate and support a program for pregnant substance abuse women, offering counseling, referrals, transportation, et cetera.

At one time we had a migrant health program. We learned a lot from serving transient individuals. It enhanced our ability to serve mobile people. New Haven has a significant homeless population. Our center has a grant to provide health services to this group.

In terms of the relatively high infant mortality rate, we have done several things to address the issue. But more importantly, some 6 years ago we worked to create what was called a Special Commission on Infant Health. The goal of the commission was to bring people together to do what we could to address the high infant mortality rate that New Haven was experiencing.

We are happy to report that the 1990 data indicate the infant mortality rate was reduced from 20.2 in 1987 to 10 in 1990. This

is a significant improvement realized through a wide community effort.

We also have looked at the need for programs for young children with special needs. We found during the 17 years that we have had this special program that we have been able to get the children on track for kindergarten, avoiding them being labeled disabled or becoming wards of society for the rest of their lives.

We have examined the issue of hunger. As you probably know, one of the major studies on hunger was done in New Haven. Since that time, there have been school breakfast programs, emergency food pantries and various other ways to get food to needy individuals in the community.

We feel that it is important to develop networks with other institutions in the community, including the health department, the university, and the medical schools.

We have more recently reactivated the Lead Paint Advisory Committee, which is again addressing problems of lead in young children.

Let me just speak briefly about some of the challenges. I think, as has already been stated, we face serious shortages in terms of identifying primary care providers and the problem becomes more acute when we look for individuals in the ethnic groups that we serve. We have simply not been able to recruit and train enough individuals in the health professions who come from the minority populations. This is something I hope that you and others would continue to pay attention to.

I think that it is important that we continue to serve as laboratories for education for our health students. In our center we have been training medical students, nursing students, dental students, and nutritionists for some time. However, there are costs associated with this in terms of decreased productivity and revenue.

It has been mentioned that we need to modernize our facilities. We simply cannot continue to provide quality care in dilapidated facilities. Many of our centers have not had the resources to modernize. We also lack space.

Finally, I want to mention the importance of our being included in the Federal Tort Claims Act. When we looked back over the past 6 years, our center had expended about \$1.4 million in malpractice insurance, yet we had only one settlement of about \$30,000. In this instance, the insurance company simply settled because the physician involved lived in the Far East and it was extremely costly to fly him in for weeks of hearings and deliberations. Changes to the law which allows coverage for our centers is extremely important.

I want to thank you and especially Mrs. Johnson for your efforts in this area.

Thank you very much.

Chairman STARK. Thank you, Mr. Scott.

[The prepared statement follows:]

**STATEMENT
TO THE WAYS AND MEANS HEALTH SUBCOMMITTEE
BY CORNELL SCOTT
EXECUTIVE DIRECTOR
HILL HEALTH CORPORATION
NEW HAVEN, CONNECTICUT**

Members of the Ways and Means Health Subcommittee, my name is Cornell Scott. I am executive director of the Hill Health Corporation, a large community health center in New Haven Connecticut, a city of 130,000 people with a high poverty rate.

I would like to present to you a model for accessibility based on the development of the Hill Health Corporation over a 25-year period. It's a model that combines traditional accessibility features with new elements. I present it because of the comprehensive nature of its approach to accessibility. It's an approach that addresses most of the health needs that inner-city populations typically present.

TRADITIONAL APPROACHES

First, let me describe the traditional approach that we use to make services accessible:

Hiring of staff who represent the ethnic and racial makeup of the patients, including bi-lingual, Spanish-speaking staff.

Contracting with the local community action agency to provide a free patient transportation system. While the city has public transportation, it is inadequate to meet the needs of sick families with children and elderly people.

Child care to enable parents to bring their small children with them to clinic appointments and have them cared for in a supervised playroom.

A sliding fee scale to reduce charges to uninsured and underinsured patients. A growing segment of our patients have lost their jobs and health insurance in the recession.

Evening and Saturday operating hours for working people.

A 24-hour-a-day medical/mental health consultation service to triage urgent problems when the Clinic is closed.

Outreach to the community we serve is conducted on several levels - home visits, newborn visits, street outreach, community health screenings and interagency collaboration.

2. Outreach workers come from various disciplines and tend to specialize in fields such as AIDS education, perinatal, homelessness, and tuberculosis.

Satellite operations. We have several types of satellites that serve special populations. One provides primary medical care and WIC in a medically underserved area across town from the main clinic. There are two WIC satellites serving the adjacent towns of West Haven and Milford. The homeless program has satellite offices in two shelters in the city. We run school-based clinics in two middle schools and participate in an elementary school clinic by providing on-site pediatric support.

NEW APPROACHES

Hill Health Corporation has gone beyond these traditional features in its attempts to make health care accessible to low-income people. I will describe these in the following areas:

1. Responsiveness to specific diseases or problems affecting the target community
2. Maximizing community/university ties
3. Internal systems

1. Responding to specific health problems

New Haven seems to have had more than its share of problems in such areas as infant mortality, homelessness, AIDS, teenage pregnancy and substance abuse. The Health Center has been at the forefront of efforts to address these public health problems and has developed services and programs to give the affected populations access to needed care.

AIDS

We were and are inundated with AIDS cases stemming from our longtime contact with the General Assistance population, which is heavily populated by injection drug users. The delivery system that was developed is meant to provide a continuum of services from early intervention to treatment, referral and follow-up. It has the following components:

1. Education and outreach. Three programs are designed to reach (a) injection drug users and sex partners, (b) minorities at risk and (c) youth at risk. Much of the outreach is done on the inner-city streets and hangouts. Condoms and bleach kits are distributed. A face-to-face approach is used primarily.
2. HIV counseling and testing. The outreach programs

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encourage at-risk persons to come in for HIV testing, which is done by two counselors on a daily basis. Seropositive patients are referred to HIV case management.

3. HIV case management. The Center has a five-member team which provides case management services to HIV+ patients, insuring that medical, social, mental health and other services are made available to patients.

4. AIDS clinical trials. This project is part of the National Institutes of Health's Community Program for Clinical Research on AIDS (CPCRA). It conducts clinical trials on new AIDS-related drugs and targets previously underrepresented populations - namely, women, minorities and injection drug users. The program gives our patients access to new therapies that would not ordinarily be available.

SUBSTANCE ABUSE

Treatment for substance abuse was not one of the original services of the Center but has been added in recent years to fill vacuums in treatment that were not being addressed by the established treatment agencies. The programs that were developed grew out of needs of our patients, for example, cocaine-addicted women coming to our obstetric service for prenatal care.

1. Medical detoxification. A 25-bed facility which focuses on the indigent chronic alcoholic population. We have been providing medical care and management to this population through a contract with the City of New Haven. Detoxification is the first step in the recovery process.

2. Intermediate and long-term care. The Grant Street Partnership began as a 44-bed shelter for homeless men with substance abuse problems combined with an on-site 90-day treatment program. It is evolving into an intermediate and long-term care program that will take referrals from the detoxification program and enable addicts to continue recovery. There is a heavy emphasis on case management.

3. Outpatient treatment. An overall shortage of beds in the community increases the demand for outpatient counseling and support services. Our new Northside Community Outpatient Services program is an option for those who, for one reason or another, cannot enter residential treatment.

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4. Support for pregnant women and mothers with substance abuse problems. Our Women's Corner project was designed for the many women in the city who could not get help in coping with pregnancy and drugs. The home-like setting of the program, daily meals, counseling, referrals, transportation, outreach, education and respite care all contribute to supporting women through this crucial time.

HOMELESSNESS

A growing homeless population led us to create a team that could travel around the city to lend on-the spot assistance and encourage homeless people to come into the clinic. The team comprises a mid-level practitioner, a social worker and a case manager. The Center organized a network of agencies and hospitals serving the homeless which has promoted collaboration and advocacy.

The creation of the Grant Street Partnership, noted above, was a logical step in extending the scope of the program to include treatment for homeless people where the treatment site and the homeless shelter are in the same facility under unified management. This innovative approach was chosen as a demonstration by the National Institute on Alcohol Abuse and Alcoholism. Results so far indicate that this is a promising approach to the twin problems of addiction and homelessness.

INFANT MORTALITY

As long as 15 years ago, the city's high infant mortality rate caused the Center to target programs and services to teenagers and high-risk women. While all these approaches may not be easily replicated, it is worthwhile to identify them as needed elements of a comprehensive approach.

1. Teenagers. We found that a program that combined intensive support, outreach, education and counseling was most effective in attaining satisfactory prenatal care and healthy babies.
2. Perinatal Department. This was an extension of the approach to teenagers, applied to adult high-risk women. It is a concentration of support, educational and counseling services within the perinatal period, following newborns and mothers for a year after delivery.
3. WIC/Nutrition. Having the Women, Infants and Children Program at our clinic meant that we could back up our education about good nutrition with the provision of actual healthy food for pregnant and postpartum women. It was also an incentive to bring families into the

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clinic where medical and dental care was available. WIC now has three satellite offices - one in a second city neighborhood and two in surrounding towns.

4. Education and child care. We brought these services on site nearly ten years ago under the "one stop shopping" concept. Pregnant students may attend an alternative public high school and obtain day care within the Corporation facilities in the Hill. The goals of getting good prenatal care, staying in school, and having accessible child care were advanced by this arrangement.

5. The Women's Corner, described above, was chosen by the U.S. Center for Substance Abuse Prevention as a demonstration of the thesis that infant mortality can be reduced by concentrating services on high risk women with substance abuse problems. Mothers of young children - they're on welfare, they may be homeless, they're young, they may have AIDS, they may be on drugs and alcohol - they need a refuge, a place of support.

6. Disabled children. We found early on that the children of families such as described above will have emotional, mental and physical deficits. It was first thought that these toddlers were retarded. Now it is known that they were developmentally delayed by the lack of home stimuli, such as game playing, physical affection, verbal communication, teaching of colors and letters, reading stories, etc. Our Early Stimulation Program has had great success with an approach that emphasizes daily play therapy in a loving and creative environment and teaches parenting skills. This program takes a child from infancy up through three years, and has had success in preparing children for Head Start and formal education.

7. Well-Child Care. Another case of "logical steps" brought us to use an elementary school-based clinic as a way of providing well child care to infants in a geographically isolated area barren of social and human services. The Brennan School Clinic, a collaboration with the New Haven Health Department, is based on the Cambridge model in that it goes beyond the student body for its target population. The lack of services in the area and poor public transportation made it necessary to develop strategies that would physically locate essential services in that community. This was also a collaborative effort, involving among others the Special Commission on Infant Health.

HUNGER

Although the clinical manifestations of hunger may not be

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apparent in our patient population, the growth of food pantries and soup kitchen throughout our target area suggests that lack of food is one of the health-related needs of our patients. Our response has been primarily in two areas.

1. Emergency food pantry. The pantry was established and continues with the help of private funds. It is open three days a week to serve patients who need a bag of food for a few days.

2. Meals/food. Meals and food are available through many of the Center's various programs and services. In some cases, the availability of food and the resulting social contact serve as an inducement for patients to come to a program. Our ability to have food on hand is heavily dependent on the Connecticut Food Bank, which sells it for only 10 cents a pound.

2. Maximizing community/university ties

Developing accessible services in these times means entering into collaborations with a variety of organizations and coalitions. Nearly all our recent expansions and enhancements of services that facilitated accessibility involved some kind of collaboration. The Grant Street program involved Yale University and the City Human Resources Department. The initial funds for the detoxification service were the fruits of state lobbying by a coalition of treatment agencies and hospitals. University ties are extremely helpful in developing demonstration proposals with intensive research components.

1. University/medical school linkages. We have been fortunate to have always had the support and cooperation of Yale University and especially its School of Medicine. The areas of cooperation are numerous, ranging from representation on the Board of Directors to physician back-up and recruitment. Clinical faculty appointments are very helpful recruiting tools. Yale's technical assistance in research projects is also invaluable.

2. Community coalitions. In addition to the homeless services network noted above, the Center participates in the following coalitions:

- A. Fighting Back Initiative against drug abuse.
- B. Special Commission on Infant Health
- C. New Haven Lead Paint Advisory Committee
- D. Mayor's Task Force on AIDS
- E. Advisory Committee on School-Based Clinics
- F. New Haven Childhood Immunization Advisory Committee.
- G. The New Haven Coalition to Eliminate Tuberculosis

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In addition to forging common strategies to deal with community-wide problems, these coalitions can be conduits for increasing the resources of community health centers. Private and government funders more readily give money to community-wide comprehensive approaches that can deliver coordinated services.

3. Systems development

Expansion of services, new programs often happen without accompanying growth in related areas of the health center. Administration, management information, clinical support, grant management, evaluation of quality - these areas tend to fall behind in the midst of service expansion. The internal management systems of community health centers must be strong also - and sophisticated. The Hill saw its staff and budget more than double in the space of five years - leaving what has been described as an "administratively flat" organization. Some important management areas are:

1. Infection control. Our pharmacy director and a committee of clinicians have put in many hours - training and orienting new employees in infection control procedures, providing in-service training, developing standards related to AIDS and tuberculosis, meeting OSHA and state licensing requirements, regular provision of inoculations for clinical staff, implementing biohazardous disposal plans and designing protocols for handling needle sticks.

2. Quality Assessment. All services and programs should be regularly evaluated internally by means of written protocols specific to the service. Medical services can be evaluated through chart audits, but how do we assess AIDS outreach? And how much more paperwork can we handle without adding more support staff? How will we evaluate a needle distribution program to injection drug users? The Center's quality assessment committee meets monthly to act as the prime mover in reaching toward better quality. When patient access was threatened by clinic bottlenecks last year, this committee organized a thorough investigation of the problem and advocated improvements. It performs a vital function but relies entirely on the "volunteer" labors of middle management staff.

3. Management Information Systems. With the help of Yale, we have developed an in-house management information unit, complete with main frame and full-time director. The system is becoming more responsive to requests for program information, as opposed to billing information. The program information data are vital for quality assessment purposes. It's also needed for reporting to funding sources, program management, enabling research questions to be answered, developing data-based rationales for new funding proposals and

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maintaining an information library to illuminate multi-year trends.

4. Case management. The more complex the health care delivery system becomes, the greater the need for providing case management services. The practice of tracking patients to insure that needed services are made available is essential to the notion of accessibility. Otherwise, there is too much of a risk that the patient will not receive the service. It is important to identify which staff are performing case management functions, how they are assigned to patients and who is the primary manager in situations where two or more staff people may be involved. Further, if an outside agency is providing case management for one of your patients, how do you relate to the outside case manager?

CHALLENGES

There are several challenges that we confront in the model that I have been describing. Foremost among them is the scarcity of primary care physicians. Such a shortage exists now at the Hill Health Center, and it is delaying access to medical care. We also experience some difficulty in recruiting other professionals, such as social workers and nutritionists, who are representative of the cultures and ethnic groups we serve. This is especially true of Spanish-speaking staff.

The role of the community health center in training medical and other professional staff should be recognized as contributing to improved access over the long run. Our clinic serves as a training site for medical students, nursing students, dental hygienists, social workers, nutritionists, and public health students. It should also be recognized that the health center bears costs when it trains medical students. Plans to increase the supply of primary care physicians should include compensation to health centers to cover the costs entailed.

Another challenge to the kind of comprehensive model we are supporting is space - does the health center facility have enough space to accommodate needed programs and services? Is the medical clinic large enough to accommodate the increased traffic flow that might be anticipated, given a broad mix of services? Can the Center provide all services under one roof? What is the role of satellite operations? In our case, the answers to these questions was, no - there wasn't enough space. We were fortunate to have the room to expand and to be able to acquire adjacent properties. Unfortunately, capital projects don't happen overnight or even in six months or a year. When a health center thinks about expansion of programs and services, it also must think about where to put the service and how to finance any needed physical expansion or renovation.

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Before closing, I will briefly mention the importance of recent changes to the Federal Tort Claims Act and their impact on community health centers. The changes allow community health centers to be covered under the Act, meaning that the thousands of dollars we have expended each year for malpractice insurance can now be diverted to direct patient care. Considering the fact that the Hill Health Center spent about \$1.4 million in malpractice insurance over a six year period and yet experienced only \$30,000 in actual malpractice claims, there is no doubt that the inclusion of community health centers under the Act was amply justified.

Thank you very much for the opportunity to present my views.

Chairman STARK. Mr. Silva.

**STATEMENT OF JOHN M. SILVA, EXECUTIVE DIRECTOR,
FAMILY CARE CENTER OF CARONDELET, INC., ST. LOUIS, MO.**

Mr. SILVA. Thank you, Mr. Chairman. My name is John Silva. I am the executive director of Family Care Center of Carondelet in St. Louis. I am also president-elect of the National Association of Community Health Centers. My health center is an urban primary care facility that provides services in an area populated by about 150,000 people and it encompasses both south St. Louis and south St. Louis County and we operate two primary care facilities, one social service facility and a soon-to-be-opened dental facility giving us the distinction of being the only dental program that will be providing care to the medically indigent and Medicaid recipients in south St. Louis.

Currently what is occurring in St. Louis is no different, I think, than what is occurring in many other large cities across the country. A number of major hospitals are merging. Catholic medical center has just announced a huge merger with both Jewish and Barnes Hospitals which are affiliated with Washington University and their medical school.

They are not the only merger, but they are the largest merger and they certainly sent tremors through the St. Louis health care community.

We have just recently become aware that these hospitals have now approached the State Medicaid, Missouri Medicaid office about competing for a Medicaid managed care contract. That is a very interesting development considering that none of these hospitals has ever been involved in delivering primary care services to either Medicaid recipients or the medically indigent for as long as I can tell. Where that leaves the community health centers and the primary care network in St. Louis is a little excited and a little apprehensive.

Maybe people are catching on that services are necessary to be delivered to these populations. Maybe what we are seeing is an attempt to kind of enroll as many people as possible so the dollars can be directed into a huge hospital conglomeration.

The focus of my testimony, however, is very brief. It has to do with barriers that we are meeting or an urban community health center is encountering in trying to provide primary health care access and delivery in an inner city.

First and foremost is the availability of physicians and midlevel practitioners, both those that accept Medicaid and the medically indigent as well as those that are willing to work at community health centers.

One of the barriers has been not only those that will accept Medicaid and the people that can't afford to pay, but also adequate reimbursement for ancillary service such as outreach and educational services attached to delivering health care to these populations.

Also another barrier is the lack of graduate medical education reimbursement targeted to community health centers that participate in residency and teaching programs with medical schools and teaching hospitals. My recommendation is the redirection of some of those dollars to reward primary care delivery settings.

This would not only assist us in recruitment and retention of providers, but would also allow us to increase services, to increase access, and to target some of those dollars for expansion of, as a previous speaker has mentioned, dilapidated or overtaxed facilities and delivery sites.

A second major barrier completely related to my last point is the lack of adequate infrastructure investment into primary care networks in inner cities. At my health center currently, I have my adult and family practice physicians using office space located in a converted supply room.

My supply room is now a trailer that we have purchased to attach to the side of our building. My pediatricians are now located in an exam room that we have cleared out and built a temporary exam room attached to our WIC offices. That is one of the problems that inner-city community health centers face.

Our facility supposedly maxed out in patient visits back in 1985 when we provided 24,000 patient visits. In 1992 in the same facility we have provided 51,000 patient visits.

There is simply a lack of access to dollars, a lack of access to capital pools, to loans, to some of the things that are mentioned in your bill, Mr. Chairman.

If some of those dollars could be targeted to our infrastructure needs, we would be able to not only expand our facility, do a better job with physician recruitment, expand our residency programs, provide additional services, including optometry, dentistry, podiatry, ultrasound testing, et cetera.

In this era of health care reform, a broad national system must be developed to assure that every American has access to comprehensive, primary health care. This will be modeled after such programs with proven effectiveness as the national network of federally funded community, migrant health center and homeless center program which currently provide high-quality, comprehensive, preventive and primary care to more than 6.5 million people who, because of poverty, disability, geographics, occupational and cultural barriers, would otherwise have little or none.

To conclude, I am recommending that any reform legislation that seeks to reduce the barriers and obstacles for access to care in inner-city locations has to include the development of community health networks that are, in fact, community-based and community-controlled and specifically those networks must, one, assure cost-effective primary health care for every underserved community by beginning an immediate expansion of the health center programs, including support for development of new and expanded centers, as well as continued support for essential services not covered by insurance, and care for those who remain outside the insurance system; and, two, make managed competition for underserved people in communities by providing support for the development of community health networks involving health centers and other safety net providers to fully organize the delivery of needed health care services there and by eliminating barriers to the development, such as the ones that I have discussed.

Thank you for your time.

Chairman STARK. Thank you very much, Mr. Silva.

[The prepared statement follows:]

**STATEMENT OF JOHN M. SILVA
EXECUTIVE DIRECTOR
FAMILY CARE CENTER OF CARONDELET, INC.**

Chairman Stark and Members of the Committee:

I am honored to be asked to be here today to share with you some of my insights and experiences concerning barriers and obstacles that currently exist for all of us attempting to provide comprehensive, primary care services to residents of urban areas and inner city locations. As the Executive Director of Family Care Center of Carondelet I have the responsibility of overseeing a health care delivery system that serves an area containing over 150,000 residents of South St. Louis and South St. Louis County and includes some of the highest incidences of infant mortality in the entire City of St. Louis. Family Care Center operates two clinic locations, as well as a Social Services Center, and within the next two months a Dental Office. We are constantly working to adapt and to change, based upon the needs and the demands of the residents of our community.

While this era of health care reform is exciting for many of us that have toiled on the front lines of health care delivery for the many years, it is also a time of apprehension and uncertainty. The decisions that will be made by this administration, and by all of you, will have serious repercussions, both positive and negative, upon countless millions of Americans currently struggling to access quality, affordable health care for both themselves and their families. As the discussion around managed competition and various manifestations of that idea continue to be debated, it is difficult for those of us in urban locations, serving a less than mainstream population, to envision a successful managed competition system without built in protections, mandates, and eligibility criteria for the medically underserved, medically indigent, and Medicaid recipients in our area.

An estimated forty three million people living in inner city and rural communities remain seriously, medically underserved because of special needs or circumstances. They are overwhelmingly poor, or low income, and are disproportionately young. Many are uninsured, but 60% of them already have some form of insurance, especially Medicaid. Many live and work in areas with too few providers of care. For example in South St. Louis, Family Care Center and the City of St. Louis clinic system are the only Medicaid accepting providers in the Southern area of the City. However, when surveys are conducted to determine medical underservice in South St. Louis and private physicians are asked if they accept Medicaid, many will respond "yes" on whatever survey document is provided. However, if they were further asked if they are currently accepting Medicaid, they would tell you that they are "all filled up" and cannot accept any additional Medicaid patients. This is not simply symptomatic of St. Louis, but exists in epidemic proportions throughout this Country. In most inner city locations, Community and Migrant Health Centers are literally the only game in town for the poor or Medicaid recipient. Our patients face serious non-financial barriers to care, such as language or physical disabilities. Many have complex health problems or are undocumented immigrants. They frequently depend on hospitals and emergency rooms for even basic care because of severe shortages of appropriate primary health care services in their communities. Even with guaranteed insurance coverage, these Americans will continue to face significant barriers to care, especially family oriented, community responsive, primary and preventive health services.

In St. Louis it is hard to imagine private group practices and upscale physician offices actively recruiting or soliciting the poor for services in their medical practice even with Universal Health Coverage. These are people that are simply not wanted in waiting rooms.

In inner city locations, barriers to access to health care services include physicians that accept Medicaid recipients and the indigent as previously discussed. However, obstacles also include the incredible need for infrastructure development so that those institutions and agencies that have been providing quality, comprehensive health care services to millions of medically underserved Americans for the last twenty years can continue to do so. Family Care Centers main site is 12,000 square feet. Back in 1985 it was believed by the then Board of Directors that 12,000 square feet would be the most space ever needed by this agency to provide primary care services to all who needed those services in South St. Louis. In 1985, the health center provided 24,000 medical encounters or visits. In 1992, in the same 12,000

square feet location, Family Care Center provided 51,000 medically related encounters or visits. It seems at times that we are providing these services with smoke and mirrors. We literally utilize every available nook and cranny within the facility. Our full time adult and family practice physicians are presently housed in our former storage area which we have reconfigured to fit five full time physician desks with very little privacy. A trailer has been purchased and is permanently attached to the side of the building in which to place all items for storage. Our OB/GYN providers currently share their exam space with optometry residents, which although they do not provide services at the same time, represent very crowded conditions for two very vital types of health care services. We even went so far as to transform one of our patient bathrooms into a consultation room for our perinatal nurses and family planning counselor.

Unlike established, for profit medical corporations and large non-profit hospital corporations, community health centers do not have access to the large sums of capitol dollars, investment dollars and loan opportunities that the much larger corporations have. In inner cities we are usually hostages to buildings that we have had donated, or purchased many years ago that have not been capable of accommodating the constantly increasing demand for services. Renovation dollars are limited and difficult to secure, capital expansion dollars from federal sources are also extremely limited. I can tell you from personal experience that if Family Care Center, for example, could expand into a 24,000 square foot facility, we would be able to easily provide over 100,000 patient visits a year which represents over 30,000 residents of our service area as opposed to the current 15,000. No health care reform package can therefore profess to represent the needs of the medically uninsured and indigent in America without a substantial infrastructure and capitol development package as an integral part of that legislation.

Another obstacle that currently restricts our ability to provide expanded primary care services and preventive care to our population in South St. Louis is the lack of availability of primary care professionals. It is estimated that over the next decade, 20,000 additional primary care physicians will be needed to furnish care in medically underserved communities through community health centers. Federal health professions programs must be substantially reformed. These reforms must include special efforts to find students who desire a career in primary care, greater emphasis on primary care in both undergraduate and graduate training, increased linkages between training programs and current primary care providers located in medically underserved communities, and greater financial and professional rewards for primary care practice. Particularly in underserved areas, support for Federal health professions education and training programs must be significantly increased.

An even greater opportunity, however, in the development of primary care providers for community based service would be the re-direction of Medicare and Medicaid payments for direct and indirect costs associated with graduate medical education (GME) and other health professional training. Estimated at over five billion dollars in FY '93, these payments are spent almost entirely on inpatient specialty based training and provide no incentives for primary care training. The Council on Graduate Medical Education (COGME), has already cited current hospital based specialty training programs as contributing to the overall shortage of primary care providers, and the severe shortage of such providers in underserved areas. Current GME policies must be revised to support expanded primary care training and to increase the number of ambulatory training programs as recommended by the Institute of Medicine, COGME, and the Physician Repayment Review Commission.

If Family Care Center could receive direct GME reimbursement for expanded training linkages and residency programs, we could expand our service capacity, we could expand our residents access to health care services, and it would certainly position us much better to recruit and retain highly qualified physicians at our facility. We currently are affiliated with a number of teaching and residency programs in St. Louis, however, we receive little or no dollars from those programs. We have no additional space available to expand into an increased teaching and developmental role. If dollars could be targeted to us to insure the development of community based primary care providers, we would be able to invest some of those resources for our infrastructure needs, developing additional clinic sites, exam room locations,

and service delivery points. Therefore at the same time that we were training additional primary care providers within our community, we would be providing vastly expanded health care service delivery to our community. This concept seems extremely logical, unfortunately however, our influence and legislative clout pales considerably in comparison to teaching hospital and academic institution resources.

While health insurance is important in assuring financial access to care, insurance coverage alone cannot guarantee access to necessary primary care. Isolated by residential, cultural and language barriers, low income Americans confront numerous obstacles to receiving appropriate health care services. Many of the Nation's underserved reside in isolated, inner city communities that face major problems attracting and retaining health personnel. In areas where a shortage of physicians exist, low income residents, especially those without health care coverage are the most likely to lack access to these limited health resources.

In St. Louis, at this precise moment, a huge hospital merger is underway between Catholic Medical Center, and Barnes and Jewish Hospitals. These institutions represent existing, large networks of county and city hospitals and Washington University's Medical School. It is clear to everyone watching from the sidelines that this merger can only spell the first step in the development of a huge network of health care delivery for St. Louis. The problem is that neither of these institutions has ever shown any interest or concern for the medically underserved, medically indigent and Medicaid populations of St. Louis City and County. It is obvious that this merger is to position themselves in a "cat bird" seat when health care reform does become the law of the land and dollars are attached to the number of patients enrolled. My concern, and that of many of my colleagues across the Country, is that in a system driven by managed competition and by capitation the emphasis will be on enrollment numbers and dollars per patient, and not by service delivery or quality of care. The least attractive patients will once again be those that manifest complex health and social problems, the homeless, the HIV positive, the undocumented residents, and the very poor.

In this era of health care reform, a broad national system of primary care centers must be developed to assure that every American has adequate access to comprehensive, primary health care. This effort can be modeled after such programs of proven effectiveness as the national network of federally funded community, migrant, and homeless health centers, which provide high quality, comprehensive, preventive, and primary health care to more than 6.5 million patients, who because of poverty, disability, geographic, occupational, and cultural barriers, would otherwise have little or none.

To accomplish this purpose health reform needs a plan and the resources to assure that by the end of this decade no American community, urban or rural, rich or poor is without adequate, comprehensive, primary and preventive health care services.

At the same time encouraging development of managed care systems under health care reform can either produce great good or great harm for the people served. Under the right circumstances managed care can significantly increase access to good quality care for most Americans providing a medical home that stresses early and timely entry into preventive and primary care services and containing costs by reducing the provision of unnecessary or inappropriate care. However, there are some areas and populations, in particular low income, inner city, and other medically underserved Americans for whom this approach could prove detrimental unless it includes steps to fully involve the providers that currently serve these areas and populations.

The currently existing health centers form the back bone of the local health care system for most underserved people and communities. They need direct assistance and support to link with each other, other safety net providers, and underserved communities to form community health networks (CHN's), focused on serving the people living there and these networks need to be appropriately recognized as managed care systems under health care reform. Moreover, current Federal laws and policies which pose barriers to network development, such as

restrictive budgeting requirements, and fraud and abuse limitations, will need to be amended to permit appropriate linkages that benefit underserved people and communities. These networks, once established, will need both recognition and special reimbursement requirements that recognize the CHN's as managed care providers/contractors. It is important to also require the CHN's and any other managed care plan serving persons who reside in medically underserved areas, or who have special needs, to subcontract with certain federally assisted entities, community and migrant health centers, homeless health care projects, public housing, health service projects, family planning clinics, etc., to provide health care services to enrolled persons. Special payment methodologies and appropriate risk limits for CHN's that participate as managed care contractors which both promote their mission and protect their solvency must be established. Finally "safe harbors" protection must be provided to CHN's and primary care centers for arrangements that reduce cost or conserve federal resources, or which improve the ability of the entities involved to provide necessary services to underserved persons and communities.

In other words, I am recommending that any reform legislation that seeks to reduce the barriers and obstacles for access to care in inner city locations has to include the following two components:

(1) Assure cost effective primary health care for every underserved community by beginning an immediate expansion of the health center programs, including support for development of new expanded centers, and continued support for essential services not covered by insurance, and care for those who remain outside the insurance system, and

(2) make managed competition work for underserved people in communities by providing support for the development of community health networks involving health centers and other safety net providers to fully organize the delivery of needed health care services there, and by eliminating barriers to their development.

a. Assure that these networks and health centers are fully included in all managed care arrangements serving (or proposing to serve), local underserved communities and populations.

b. Assure adequate payment rates and stop loss coverage to the networks and health centers to promote their mission, recognize the complex needs and mix of patients they serve and protect their solvency.

CONCLUSION - There is no better way for this committee to work to ensure access to health care for all inner city residents than to focus attention during the health care reform debate on infrastructure development. In South St. Louis, if Family Care Center was provided the resources to effectively compete in the market place for the recruitment and retention of physicians including:

- ▶ the targeting of GME dollars directly to community based organizations such as mine for the development of training and education programs for medical students and residents,
- ▶ resources targeted toward the development of physical facilities including expansion of current locations to continue to meet the need of the medically indigent, underserved, and Medicaid recipients in our area,
- ▶ a federal mandate that Community, Migrant and Homeless Health Centers (and other safety net providers) would have to be included in any managed competition plan as an essential provider,

then I can assure you that within the next five years through this type of investment in community, migrant, and homeless health centers, Family Care Center could more than double the amount of medically at risk individuals that it provides low cost, high quality, comprehensive health care to in South St. Louis and South St. Louis County.

Thank you for your attention and the opportunity to share my thoughts with you.

JMS:pjm

Chairman STARK. Before I begin the inquiry, I just wondered, Mr. Scott, I thought I heard you say something about a tort reform bill that the gentlelady from Connecticut was connected with. I wonder if you would like to repeat that just to make sure the clerk has it correctly.

What was it you said, Mr. Scott?

Mr. SCOTT. I had indicated that we did a recap over the last 6 years and we had spent in excess of \$1.4 million on malpractice insurance and during that time we settled one claim amounting to \$30,000, and that was done simply because the physician who was involved lives in the Far East and had to be flown back for testimony and hearings which went on for weeks. The point that I wish to make is that potentially centers, through FTC participation, can have millions of dollars which can be utilized to expand badly needed primary care services. Mrs. Johnson was most helpful in her advocacy for changes in the FTC to extend coverage to community health centers.

She visited our programs, talked to many of us at length, and kept coming back for additional information. We are indeed grateful to you, Mrs. Johnson, for your friendship and strong support.

Chairman STARK. I thought you said something.

Thank you very much.

Mr. SCOTT. Thank you.

Chairman STARK. Mr. Silva, your statement discusses the reluctance of providers to treat Medicaid and indigent patients, and while the Chair is inclined to excoriate them who do that, principally for the reason that they become so sanctimonious about what great care they give to the world at large while spending great sums of money with their sales efforts to avoid providing uniform care to all citizens.

Now, if they would be up front about it, maybe we could solve the problem, but can you shed some light, if we can figure out why they go to such great lengths to avoid the Medicaid population, perhaps we would give them the proper incentives to do the right thing. In the absence of that, perhaps we could enforce it.

So I guess my question is, how do we address this issue of determining, one, other than it is just a social distinction and somehow somebody might think that poor people aren't nice, but let's skip that and presume that nobody is that bad and that there are special problems that these managed care people are just not competent to address.

How can we work this out? Do we just have to do it by law and say everybody is going to be in a pool and you have got to randomly do like risk assignment in the auto insurance business, or is there something we could do to pay, to increase training, to make it attractive for these providers to encompass the entire population in their networks?

Mr. SILVA. Well, Mr. Chairman, I think there are a couple of responses. First of all, I think the providers would tell both of us that it is basically due to low reimbursement rates by the fact that whenever some States fall short of money at the end of budget year, that they begin to hold back Medicaid reimbursement to providers, but I also think that it points to a larger problem that I think community health centers and migrant health centers and

homeless health centers could address, and that is a recognition that a lot of these patients present more than just medical problems, that they present sometimes social problems, homeless problems, nutritional, substance abuse, physical abuse problems that private physicians are not equipped to handle, that they would need not only to deal with their medical problem, but also to deal with the whole host of social problems or develop their own referral networks, and these people are not very mobile.

I think one of the approaches to that is to recognize community health centers as essential providers and try to develop that type of model in medically underserved areas.

The one-stop shopping concept, which I hate, I hate that term, but the idea is appropriate. The one-stop shopping concept of developing a facility, reimbursing it appropriately and providing the medical and the social services necessary to provide that health care will take a little bit of the pressure off the private physician.

Right now there is just not enough access to those types of facilities, and so for us—

Chairman STARK. Why should we make it socially unacceptable to say that certain physicians are doing something wrong by ignoring certain areas of the population? Why not accept it. It is like redlining.

If we accept that redlining exists, then let's do something about it. If the bank doesn't want to lend down on Elm Street, then let's allow a credit union down there that will meet the needs of the people.

So in medical care, what is wrong with deciding that in some rural areas, some inner-city areas, good government, whether it is the Federal or the State or the city government is just going to have to operate medical delivery facilities that are designed, they will probably be far less efficient because people aren't used to taking annual physicals.

They may have a language barrier. Maybe the transportation problems are unique, and you could go ahead and say that this is a function of government and therefore it isn't socialism and somehow come to an agreement with the for-profit side of the delivery care system, and say, let's organize. Let's fund public institutions to provide this.

Is that a better solution than trying to dance around the maypole and let everybody say, well, we will compete for those folks or we will pretend that the system will be transparent, you won't know who is rich or who is poor? How do the others of you, Mr. Nycz or Mr. Scott, respond to that approach?

Mr. NYCZ. I think it presents particular problems for rural areas because from a health planning perspective you may have adequate capacity in the area, but the providers have decided for one reason or another they no longer want to see these people, and if that is the case, the introduction of a second system for a small fraction of the population just won't be practical. So I think we have to find other ways.

We have a situation in central Wisconsin where the Southeast Asian community has grown tremendously in many midsized communities like Wausau. I participate in an area health education center program, which I believe to be an excellent program de-

signed to address the maldistribution of health professionals. We had a presentation back home not too long ago where Mr. Tom Xiong, who worked in the refugee camps, is a health care advocate for Southeast Asians. He said that local providers are no longer accepting new medical assistance patients, and I think that is across the board, not just the Southeast Asian population. What has happened as a result of that is they must arrange for transportation to the Marshfield Clinic or the Rice Clinic in Stevens Point. Both are willing to see these folks, but transportation has to be arranged, and while they receive care, it is an awkward solution to force them to move out of their community to get care that is otherwise locally available.

I think a better solution would be to provide help to the local providers. Clearly they have a case in the sense that many have been overburdened. I think when a population in a community of 38,000 to 40,000 has grown by 5,000 or 6,000 Southeast Asian refugees and the majority of them are still on medical assistance, the community providers should receive assistance to provide services to all.

So a helping hand in that sense might send a signal to a lot of providers to not abandon such patients.

Mr. SCOTT. I guess, Mr. Chair, my comment would be, I think that you can create effective alternatives, and as we have indicated, we feel that the models that we have developed worked extremely well. As a matter of fact, I would venture to say we have not seen anything that is more effective. I think that there could be a role for the local and Federal Government to create more of these centers and institutions to respond to those needs. I think that in time we may see some change in behavior.

I can recall, for example, at one time we had under contract a private cardiology group and we were referring Medicaid patients and there were always excuses, the billings and all of that, and we offered to send a person into the office to do the billings and—

Chairman STARK. I am sorry, Mr. Scott, I have to interrupt for a minute. We will return, but we have 3 minutes left to vote. Excuse us.

[Recess.]

Chairman STARK. I appreciate the witnesses's indulgence and let me recognize Mrs. Johnson at this point to inquire.

Mrs. JOHNSON. Thank you. Thank you, Mr. Chairman.

I am awfully sorry that I had to miss some of your testimony and I haven't had time to read everyone's testimony but there are two things I want to pursue with you.

One is while we talk about expanding access, you actually do it. And it is very impressive, the expansions and the developments in the community health centers this year over just last year or a year before that. In the preceding panel it was very impressive to see the many ways in which hospitals are trying to create for themselves the outpatient care and the frontline care that will reduce costs in their emergency rooms and improve the quality of care enormously. When you look at your ability to expand, several years ago you gave me the estimate that for \$300 million more a year, you thought you could serve the uninsured.

Now, since that time AIDS has become a much more serious problem and a number of things have changed, but what is most key is your expanding, recognizing that no institution can expand more rapidly than a certain pace for itself.

Now, when you look ahead, in expanding your ability to serve the community within your reach, what is most important to you? Infrastructure expansion, outreach, money for medical professionals? What do you see as most critical to you?

That is one part of my question. The other part of my question is that I understand that you have succeeded in immunizing about 95 percent of your clients and that is an absolutely remarkable record, and so perhaps as you talk about how you are going to develop in the future you could talk about how you achieved that level of preventive care in the past.

Any one of you can answer that. I mean all of you I hope will comment on this.

Mr. SCOTT. Thank you.

Mrs. Johnson, I feel for us the top priority would be strengthening the infrastructure, and we would start with primary care providers. We simply need to train more, to produce more, to get more in the field, and that would be the first thing.

Given providers, I think we could look at facilities. Facilities I don't think for many of us would be as critical as finding providers. I think adequate space is critical but I think we could work to meet this challenge.

With regard to immunization, you are absolutely correct. One of the keys for us has been the outreach and patient pursuit. That evolves because we get people into care and we cannot only immunize but address the other problems as well. I believe the key is making sure all families and individuals are limited to primary care providers where comprehensive services are available and accessible, including immunization.

Mr. SILVA. For us in St. Louis, it would be infrastructure first, but as opposed to Mr. Scott, it would be actually physical facility. We have a number of residency programs and affiliations with hospital based teaching programs, as well as with one of the medical schools.

We actually can't even take any more residents right now, let alone hire any more physicians that would like to practice at our main facility. I had said during my testimony that back in 1985 our main building is 12,000 square feet and it was felt that we had maxed out with 24,000 patient visits provided in that space.

This past year we provided 51,000 patient visits in that space. We are literally using every nook and cranny. The problem for us is that it is very difficult to access any dollars for capital, any loan pools, because we are a private, small, nonprofit that is very dependent—about 50 percent of my budget comes through the Federal 330 grant program for community health centers. That would be number one.

Recruiting physicians and also being able to take advantage of opportunities. Right now, St. Louis County has been talking to us about taking over one of their clinics. We have moved and expanded into another facility in the central corridor of St. Louis. We

are also talking to a rural county two counties away about moving into their area. All of that is exciting.

They represent opportunities for us to provide service to the medically indigent and Medicaid recipients that are not accessing services at this time. We don't have the dollars to even begin to explore that. If there were some State dollars, some Federal dollars, and some private dollars, and I stress private dollars, private investments, maybe through private hospitals, that some of those have quite a few dollars, let's say back in secured savings locations.

If there were those types of partnerships available, we could be providing an awful lot more health care. The last thing on immunizations is we provide our patients—I would say are better than 95 percent immunized. Anybody who walks through our doors, any child, that is one of the first questions we ask.

One of the problems and this may be a surprise or may not be a surprise, is accessing adequate levels and adequate numbers of vaccines. The CDC will tell you that there are adequate levels available and they go to cities and they go to States. We always run up against the wall about halfway through the year of accessing adequate vaccines and adequate supplies at a cost that we can afford because we don't charge those patients for those services. That is a major problem, at least in St. Louis.

If there were more vaccines and more immunization supplies available, we would do more outreach and even hit more people that aren't our patients.

Mrs. JOHNSON. Interesting. Yes?

Mr. NYCZ. I would like to reflect back on a comment that Congressman Gunderson made earlier related to the low number of health centers in the Midwest. We have been out working with communities where there are needs. I think there area very well meaning providers and others who I believe we could enlisted to create more health centers in regions where currently there are few. We can't think just about expansion in our own facilities, which I want to stress is important, but to really penetrate the communities and provide much broader coverage, we have to recruit more people into the fold. I think all health centers are ready, willing, and able to assist other communities to provide the kind of services that we have been successfully providing in our own communities.

So I think reaching out and helping to develop health centers in other needy areas is something that should also be given priority.

Mrs. JOHNSON. Two last questions that are sort of related. When you look at all the various sources of Federal money coming into your urban areas, has there been any talk about integrating those moneys so that they would be more focused and do you think there could be a bigger bang for the buck if we integrated all the Federal health dollars that come into a city and gave them a single source and single governance, almost one stop shopping—could you do it at one-stop shopping?

I am looking at integrating the funding sources and providing greater management and greater local control. That is also part of the other half of my question, which is, have many of the community health centers begun to look at what kind of relationship they could develop with a hospital to become an accountable health plan

of the type that the administration is looking at, to be a comprehensive system?

Mr. SILVA. We are currently talking to a couple of the hospitals in St. Louis as well as some of our primary care colleagues into developing a primary care health plan, Medicaid managed care model for primary care.

Yes, we are doing that. If we are not doing that now, you must not have been reading the paper and watching the TV the last couple of years. I think in terms of rolling all the Federal dollars into one pot so that there would be a bigger bang for the buck, my only concern is that when you get to state and when you get to even local control, we become then part of a larger budgetary battle that will take place every year about who is going to control those dollars, where those dollars are going to be targeted to.

I think the idea makes an awful lot of sense if there is some type of mandate or Federal enforcement that these dollars are targeted for A, B, C, and D. So that, you know, when a city runs short or a State runs short, some of that money is not funneled off into other health-care related activities, which I think would defeat the whole purpose.

The idea is great. The protections must be there, though, I think.

Ms. JOHNSON. Thank you.

Mr. SCOTT. Yes. I think it would make a lot of sense to have better integration of the dollars, and with that would come some consolidation of service.

But I share the same concerns the gentleman has expressed. That unless the dollars are carefully targeted, we will get caught up in the political process; and we will have real difficulties. Because all too often who gets the buck is not based on the product, it is based on who happens to know whom. And that is a concern.

But certainly, the concept—and we discussed this—makes good sense. We, too, have been working with the two hospitals in our city to see if there are areas where collaboration would be beneficial.

As you know, many of the hospitals have primary care centers and some have been struggling to survive. In some instances, they have even suggested combining or consolidating services. This would make good sense in situations where reimbursement is low and resources are so limited that services suffer.

Ms. JOHNSON. Thank you.

Mr. NYCZ. I don't really have anything to add.

Ms. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. I want to thank the panel very much for their participation and look forward to working with you in the time period ahead as we work on this program.

Our final panel will be comprised of the following witnesses: Mr. Peter Whitten, representing the National Rural Health Association. Mr. Whitten is director of planning and development at the Upper Hudson Primary Care Consortium in New York; James Bernstein, the director of the North Carolina Rural Health and Resource Development; Charles McGrew, who is director of the Section of Health Facility Services and Systems for the State of Arkansas Department of Health; Todd Linden, who is administrator of the

Greene County Medical Center, Jefferson, Iowa; and Eugene Pawlowski, president of the Bluefield Regional Medical Center, Bluefield, W. Va.

I will be glad to recognize Mr. Grandy.

Mr. GRANDY. I just want to offer my personal greeting to my constituent, Mr. Todd Linden, Greene County and the City of Jefferson, which is the county seat located in my congressional district. Mr. Linden is one of the many kinds of rural health resources that I depend upon, and I particularly look forward to his testimony today as we try to thread through some of these essential access issues.

I just want to welcome him to the panel.

Chairman STARK. Welcome.

And, Mr. Whitten, we will begin with your summary.

STATEMENT OF PETER B. WHITTEN, DIRECTOR OF PLANNING AND DEVELOPMENT, UPPER HUDSON PRIMARY CARE CONSORTIUM, GLEN FALLS, N.Y., ON BEHALF OF NATIONAL RURAL HEALTH ASSOCIATION

Mr. WHITTEN. Thank you, Mr. Chairman, Members of the subcommittee.

My name is Peter Whitten. I am here today representing the National Rural Health Association, as well as my employer, who is the Upper Hudson Primary Care Consortium, and also one of its very exciting projects, the Adirondack Rural Health Network.

I want to thank the subcommittee for this opportunity to contribute to its deliberations on legislation pending before this body. I am pleased to share some details about a model of cooperation which New York State has adopted as the infrastructure of choice for the development of rural health care networks.

Let me take you back in time a bit. As the supply of medical practitioners decreased nationally in the late 1970s and the difficulty in attracting new physicians to the rural areas became more widespread, several health centers in northeastern New York joined forces to develop a regional strategy which would ensure the survival of primary health care services.

Federal section 330, rural health initiative funds, helped support a formal coordinated effort among the several health centers and enabled the creation of a new kind of organization called the Upper Hudson Primary Care Consortium.

This organization has been largely responsible for not only the continuation but also the expansion of primary health care services throughout our large rural region. The consortium was formed in 1987 as a not-for-profit corporation. It is licensed under the State of New York public health law, article 28, the hospital and facility enabling legislation, as a central service facility. It was originally created as an umbrella administrative agency for the founding health centers.

While these health centers continue to exist as sovereign organizations and retain their own boards and directors and administrative staffs, they also enjoy membership status in the consortium. Because these member centers have many common interests and needs, the consortium provides a mechanism for them to share re-

sources and a forum where issues essential to primary care can be addressed.

The governing body of the consortium is comprised entirely of directors of the boards of each member center. It is most beneficial to have the consortium led by its founder, who was also the founder of the area's pioneer health center and the chair of Governor Cuomo's health care advisory board, Dr. John Ruggie.

It is helpful, as well, that the consortium retains its own administrative and technical staff for the execution of its core activities. Those activities are, indeed, diverse, and time today permits only a brief recognition of a select few.

First, there is the recruitment, employment, deployment, and retention of primary care physicians and midlevel practitioners. This is an activity that is undertaken on behalf of all the member organizations in a joint fashion.

Second, there is practice development through formal affiliations with key private and group practices, which are located in low primary care access areas. These are primary care providers who operate out of their own offices, primarily seeing other than indigent and Medicaid patients but for whom we have been able to establish a relationship and a flow of funds that allows them to see underserved populations.

Third, there is a regional quality assurance program for primary care providers, including the affiliated private practices. The activities in their offices come under scrutiny by this quality assurance system.

And finally, there is a physician education program undertaken in partnership with the Albany Medical College, whereby the consortium member sites will serve as the college's rural campus.

Now, more relevant to your interests in these hearings today, I think, are the consortium's experiences with network development.

Membership in the Upper Hudson Prenatal Services Network includes a broad spectrum of prenatal health care providers from 80 agencies in 7 northeastern New York counties.

Network activities support outreach and education to increase the participation of women and children in prenatal care and infant and well-care programs, to assess and respond to gaps in the prenatal delivery system, and to facilitate resource sharing throughout the prenatal care provider community.

County-operated, certified, home-health services in the same seven counties have come together to form the Adirondack Home Health Services Network, which jointly purchases health care related services in order to leverage the marketplace and increase cost efficiency.

The public health directors of these counties have designated the consortium as their common purchasing agent, a role which we are also playing for our member health centers and affiliated private practice physicians.

In addition, the creation of this network has enabled the establishment of a mobile immunization program targeted to the under-immunized, 2-year-olds in all seven counties.

Finally, the Adirondack Rural Health Network is one of four New York State demonstration sites for the Federal rural health network initiative. Its current membership includes providers of emer-

gency services, long-term care, acute inpatient care, mental health, public health, substance abuse, and primary care.

Network participants come together with a common mission of ensuring that all citizens in the region have access to basic and vital health care services.

If I could leave you today with only one set of thoughts, they would be these: Providers of health care services to rural populations want to work together. They need a proven structure in order to do so. And their meager operating budgets contain no money for the development of necessary infrastructure.

New York State is now using an interesting model, the model of the Upper Hudson Primary Care Consortium, for the development of rural health care reform.

We sincerely, and we think modestly, suggest that it might be a form of infrastructure that you might wish to look at as well.

We thank you for the opportunity to share these experiences with you today.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF PETER B. WHITTEN, DIRECTOR,
PLANNING AND DEVELOPMENT, UPPER HUDSON PRIMARY CARE
CONSORTIUM

Mr. Chairman. Members of the Subcommittee. My name is Peter Whitten. I am here today representing the National Rural Health Association, as well as my employer, the Upper Hudson Primary Care Consortium and one of its very exciting projects, the Adirondack Rural Health Network.

At the outset, I wish to thank the Subcommittee for providing this opportunity to contribute to deliberations on legislation pending before this body and to share at the same time some details about one model of cooperation which seems to work in the health care arena with which I am most familiar.

The Upper Hudson Primary Care Consortium takes its name from the Hudson River, more precisely that stretch of river which from its source and for the next 50 miles is navigable only by canoe and kayak. For numerous reasons, that section of river was a bonding agent for the people living along and near the river from the time of French and English settlement until the 20th century.

In order to best understand the valuable role of the Consortium, it is useful to travel back to the last decade of the 19th century. At that time, many communities in this pristine Adirondack Mountain area, situated at the mid-way point between New York City and Montreal, saw their populations peak. Over the half century or so that followed, year-round populations became smaller and services harder to find.

While change didn't happen overnight, by the 1970s and '80s the availability of good, basic health care, dependent upon general practitioners and small community hospitals, began to vanish. Physicians retired and small hospitals could no longer compete with larger, more central facilities. At the same time, the medical profession was changing, with more and more physicians opting away from general practice, toward the rewards of specialization.

Nevertheless, there were medical professionals who were determined to remain in the upper Hudson region. To their credit, they saw the need for creative solutions to the area's health care challenges. These included shifting demographics, economic change within communities, rising health care costs, more accountability required by regulating agencies, and the logistics of serving a widespread patient population.

The first solution came in the late 1970s with the formation of Hudson Headwaters Health Network, a pioneering rural health care organization that utilized a team approach to combine the attractions of a small-town practice with the advantages of an urban-sized group of practitioners. Hudson Headwaters was and is a network of health centers operated with the cooperation and financial support of communities that dot the upper Hudson River area, offering primary care to year-round residents, seasonal residents and visitors who would otherwise have no local health care.

As the supply of medical practitioners decreased nationally, and the difficulty in attracting new physicians to rural areas became more widespread, several other health centers in the northeastern New York region joined Hudson Headwaters in an effort to develop a regional strategy to ensure primary health care services would survive. Federal Rural Health Initiative (Section 330) funds helped support a formal, coordinated effort among several health centers and enabled the creation of a new kind of organization called the Upper Hudson Primary Care Consortium. This organization has been largely responsible for, not only the continuation, but also the expansion of primary health care services throughout our large rural region.

The Consortium was formed in 1987 as a not-for-profit corporation. Licensed under the New York State Public Health Law's Article 28 as a "Central Service Facility," it was originally created as an umbrella administrative agency among four health center corporations located in the upper Hudson region. These health centers continue to exist as sovereign corporations and retain their own Boards of Directors and administrative staff, but in addition enjoy membership status in the Consortium. Because these member health centers have many common interests and needs, the Consortium provides a mechanism for them to share resources and a forum where issues essential to primary care can be addressed.

The Consortium is governed by a Board of Directors which is comprised of directors from the Boards of each member center. It is most beneficial to have the Consortium led by its founder, who is also the founder of Hudson Headwaters and the Chair of Governor Cuomo's Health Care Advisory Board, Dr. John Rugge.

It is also vital that the Consortium retains its own administrative and technical staff for the execution of its core activities. Those activities are indeed diverse as the following descriptions of member services, key activities and network development will attest:

CONSORTIUM SERVICES PROVIDED TO MEMBERS :

- Recruitment, employment, deployment, and retention of primary care providers (Physicians, Physician Assistants, Nurse Practitioners)
- Administrative and technical support
- Regional quality assurance program for primary care providers, including affiliated private practice
- Joint purchasing service for medical supplies and equipment
- Upper Hudson PRIMECARE program, which draws upon the New York State Primary Care Initiative funds to reimburse affiliated private practitioners for the primary care of low-income, uninsured patients
- Clinical rotations for medical students and residents focusing on rural health and primary care (in conjunction with Albany Medical College)
- Resource development, grant writing and strategic planning
- licensure and regulatory assistance.

CONSORTIUM'S KEY ACTIVITIES :

Primary Care Development Program

The goal of this initiative is to create a high quality, fully accessible and cost-effective primary health care delivery system at the regional level. This goal will be realized through the recently created partnership between Glen Falls Hospital and the Upper Hudson Primary Care Consortium. The Consortium acts as a community-based coordinating arm establishing formal affiliations with private primary care practitioners in the region. The Glens Falls Hospital, as an integral part of the regional health care network, provides ancillary services, hospital-based technology, and the financial and programmatic support for primary care development activities. The resulting system will be a replicable model for regional, comprehensive cost-effective and coordinated primary health care which is designed to equitably serve the needs of all citizens, including the indigent and medically underserved.

This project consists of three main thrusts:

I. Practice Development :

The Hospital and the Consortium are establishing formal affiliations with key private group practices which are located in the "low primary care access areas" designated by New York State. Six private practice groups representing 17 physicians are now participating in a regional primary care network. The first objective of the practice development component has been the expanded availability of primary care services to the indigent and medically

underserved through a fee-for-service reimbursement mechanism, operated under managed care principles and using Primary Care Initiative development funds.

II. Regional Quality Assurance

The Consortium is developing treatment protocols for primary care conditions typically treated in the outpatient setting. In addition, a uniform patient satisfaction survey is now administered to patients of all affiliate practices, with results aggregated, interpreted and provided back to physicians. A schedule of clinical audits of private practitioner charts has been established, to include three audits per year with each affiliate practice.

III. Physician Education Program

The Consortium and Albany Medical College have combined efforts to develop a new primary care education and training program for the region. With the Consortium serving as the College's rural campus, medical student and resident rotations will be offered in a variety of primary care settings, further bridging the relationships between community health centers, private practices and the community hospital. By enabling medical students and residents to experience all aspects of a regionally organized delivery system, particularly in underserved rural areas, it is anticipated that this will increase the number of physicians choosing primary care specialties. In addition, this program will create added visibility for the regional system, enhancing the prospect for maintaining an adequate network of primary care providers into the future. Implementation begins in the Fall of 1993.

NETWORKS :

In addition, the Consortium is developing even broader systems of rural health care which go beyond the usual boundaries of primary care. Each of the following is an unincorporated activity led by our Consortium.

Upper Hudson Prenatal Services Network

This program assesses and responds to maternal and child health care needs in the seven counties of northeastern New York. Membership includes a broad spectrum of prenatal health care providers from eighty agencies in all seven counties. Network activities work to increase the participation of women and children in early prenatal care and infant well-care programs, assess and respond to gaps in the prenatal care delivery system and to facilitate resource sharing throughout the prenatal care provider community.

Adirondack Home Health Services Network

Seven county-operated Certified Home Health Services have come together to jointly purchase health care related services in an attempt to leverage the marketplace and increase cost efficiency. The Public Health Directors of these counties have designated the Consortium as their common purchasing agent, a role we are now also playing for our member health centers and affiliated privately practicing physicians. In addition, creation of this Network has enabled the establishment of a mobile immunization program, which is quickly being recognized as a model for many other rural areas.

Adirondack Rural Health Network

The Adirondack Rural Health Network is one of four New York State demonstration sites for the federal Rural Health Network initiative. Its current membership includes service providers of emergency services, long term care, acute inpatient care, mental health, public health, substance abuse and primary care.

The significance of this initiative has been increased by the recent introduction of Governor Cuomo's health care reform legislation, which expands the Consortiums model, establishing

provisions for licensed "central service facilities" to organize regional rural health care systems. These regional Networks will be comprised of a broad range of health care providers and will be responsible for coordinating planning, sharing resources, and providing a forum for anticipating and averting major health service failures in outlying rural areas.

This "central service facility" designation is, of course, the same designation which facilitated the creation of the Consortium, originally. Six years of network-building, some say the creation of Russian dolls inside of Russian dolls, are about to yield results far beyond our initial expectations.

The Upper Hudson Primary Care Consortium region is now home to a new generation of health care providers. They are professionals of all ages who bring new ideas and enthusiasm to the challenges that exist in rural health care. They are dedicated to the idea of reaching a patient population that includes a full spectrum of economic and social status across a broad and varied region. They believe that good, basic health care should be accessible to all.

The Consortium also represents a diverse group of organizations and ideas about health care which are innovative and exciting: That health care systems can be revitalized, and designed to service effectively and economically; that they can be creative and responsive in solving community health care problems; and that they can offer rewards to practicing medical professionals that balance financial satisfaction with old-fashioned social responsibility.

We believe in the utmost importance of providing excellent primary care. Without this there can be no health care reform. We believe we are succeeding through the combined efforts of many individuals and agencies, operating in an underserved rural setting and linked together by a common goal. Our future success, and that of our colleagues all across this nation, depends on the promotion of an environment within which networks of varied shapes and sizes can develop. In New York State, that environment has included the existence of the federal EACH/RPCH program which has provided an impetus for local and regional network development. Continued support of that initiative, with some additional flexibility to facilitate idiosyncratic local conditions, is an important element of health reform legislation. Especially important is the passage of the EACH/RPCH program amendments currently under consideration by Congress.

Finally, we cannot overstate the need for resources to support the development of network infrastructure so that this aspect of reform might be effectively implemented. The Upper Hudson Primary Care Consortium has always been dangerously relegated to a "hat in hand" approach. Yet, had it not persevered, it is likely that essential health services in our isolated mountain region would have been lost, perhaps never to be rebuilt.

New York State is now using our model for rural health care, and we sincerely hope that Washington will also consider it closely.

Thank you again for the opportunity to share our experiences with you.

Chairman STARK. Mr. Bernstein.

STATEMENT OF JAMES D. BERNSTEIN, DIRECTOR, NORTH CAROLINA OFFICE OF RURAL HEALTH AND RESOURCE DEVELOPMENT, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES

Mr. BERNSTEIN. Good afternoon. My name is Jim Bernstein, and I am the director of the North Carolina Office of Rural Health. Our office has helped to develop 55 community-based health centers using only modest State funding.

We have also recruited more than 1,100 providers and give technical assistance to many small rural hospitals.

I appreciate the opportunity to be on this panel today and to share with you my thoughts on health care in rural America.

More details are in my full written statement; but, briefly, my concerns are the primary care provider supply, the need for capital for the development of coordinated networks, managed competition and rural choice, and the essential access community hospital program.

First and foremost in my mind, the challenges facing rural health care today hinge on the supply of primary care providers.

The need for more primary care providers has been demonstrated extensively and will only increase under any health care reform plan that employs a so-called gatekeeper or managed-care model.

However, the immediate supply of primary care physicians has already been determined. Students who will complete residencies in 1998 have selected their fields of study. It will take a minimum of 5 to 7 years to change the course and direction of the "aircraft carrier," "Medical Education."

Government, both State and Federal, has the opportunity to pursue a number of strategies in order to address this shortage.

In the short-term, meaning the next 5 to 7 years, we should work to decrease the existing income gap between generalists and specialists by providing preferential reimbursement to primary care practitioners in medically needy areas under Medicare and Medicaid.

As an interim step, public moneys invested in medical school students could be tied to service in medically needy communities. Medical students receive significant subsidies in Federal and State funding and could be required to pay back those subsidies in one of several forms, such as cash, a debit to their State's Medicaid system or any State Medicaid system, or service in a medically needy community.

We can no longer continue to invest millions of dollars in the education of students who choose to subspecialize in fields with a current oversupply and/or who locate in areas overpopulated with physicians and lawyers.

I recommend consolidating all State and Federal funding for medical training, such as indirect medical education, direct medical education payments, health profession dollars, and leverage all State funding for medical education.

These expenditures could flow through the State according to an approved State plan for health professionals that meets Federal

guidelines and criterias. Medical schools and States without approved plans would not be eligible for NIH research dollars.

In the long-term, given the increasing emphasis on preventive and managed care, primary care providers will be in great demand. I hope that this increased demand will not only close the gap between the incomes of generalists and specialists physicians but will finally empower primary care providers.

Primary care physicians are in demand in almost all locations, and I believe that this greater flexibility for practice location may become the strongest incentive yet for enticing young physicians to choose primary care.

If you want to go into practice in your district, Mr. Chairman, in many specialties, you have to be a primary care physician.

To move into another area of concern, rural health systems are currently starved for capital. Capital funding needed for rural projects is not significant when compared to the infusion of money going into health care today.

I suggest three components to help rural communities compete for capital to improve access, and control costs. One, health planning and, at a minimum, facility planning, and a maximum—not a maximum—a second part would be to have technical assistance built into the States to develop networks.

The second is we need certificate-of-need laws.

And, three, we need to pool our capital fund.

To achieve a policy of at least 50 percent of capital funding currently provided through Medicare and Medicaid should be earmarked for a central State fund and augmented through the sale of bonds. The States would distribute this funding based on a state-wide plan so that rural and inner-city facilities have fair access to capital.

Managed competition. Managed competition offers rural communities an opportunity to enhance their health care systems.

The final rules that regulate managed competition are critical to what happens in rural inner-city areas. We can't have minimum regulation which will leave rural areas further behind. Nor can we have the other extreme, overregulation, which could lead to monopolies in rural communities, severely limiting patient choice.

The best vision is for managed cooperation that forces the development of a rational health care system in rural areas, one that maximizes scarce resources and encourages, even rewards, collaboration. Such a new system would enhance rural health.

Finally, I wish to address the Federal Essential Access Community Hospital Program. And there is an excellent report which I think was sent to you recently from the Alpha Center, funded by the Robert Wood Johnson Foundation, which goes into a lot of detail on the EACH program.

Overall, my comments on EACH are that the current regulations are too prohibitive. This has already created obstacles to the program's implementation.

Second, I believe all States should be allowed to participate.

Third, going against the atmosphere of safe sex, I recommend more emphasis on multiple partners for the rural primary care hospitals, meaning both urban and rural partners and not just hospitals, but also community health centers and others.

Finally, the Federal Government should allow States to sponsor special demonstration programs that further experiment with the EACH concept. And I could go into more detail on that later.

Although our progress has been slow, the EACH program is going in the right direction. This is an important Federal program for rural health as opposed to the Rural Health Care Transition Grant program, which a recent evaluation by Mathematica concluded was not successful in creating positive changes in rural areas.

I suggest folding EACH and rural hospital transition programs into a national network building program based on EACH program concepts.

Thank you for your time and the opportunity to come before you today.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF JAMES D. BERNSTEIN
 Director, N.C. Office of Rural Health and Resource Development
 North Carolina Department of Human Resources

Before the Subcommittee On Health
 Committee On Ways and Means
 U.S. House of Representatives

June 24, 1993

Good afternoon. My name is Jim Bernstein, and I have been director of the Office of Rural Health and Resource Development in North Carolina since its inception in 1973. Our Office has helped to develop 55 community-based, community-operated health care centers, using modest state funding, and has recruited more than 1,100 physicians and other health professionals to rural and inner-city communities in our State. In recent years, we have augmented our program to include technical assistance to small rural hospitals.

I appreciate the opportunity to be on this panel today and to share with you my ideas and concerns about health care in rural America.

The Primary Care Provider Supply in Rural America

First and foremost in my mind, the challenges facing rural health care in our nation today hinge on the supply of primary care (or generalist) providers, on whom rural Americans depend most for care. In 1991, 40 percent of the available residency slots in family practice, general internal medicine, and general pediatrics went vacant in the national match. This figure has gotten better in the past year or so, but there is still only a trickle of primary care physicians being produced in this nation, particularly relative to the need for their services.

The need for more primary care providers has been demonstrated extensively and will only be heightened under any plan that employs a so-called "gatekeeper" (for lack of a better word) model. Increasing demand and subsequent rural shortages of other primary care providers, such as physician assistants, nurse practitioners and certified nurse-midwives, has been remarkably similar to the physician shortage.

However, the immediate supply of primary care physicians has already been determined. Students who will complete residencies in 1998 have selected their fields of study, and it will be at least five, perhaps seven, years before the current group of medical school students, who will be influenced by long-term changes, are available for primary care practice. Thus, it will take a minimum of five to seven years to change the course and direction of the "aircraft carrier" *Medical Education*.

To compound the shortage, rural communities are getting squeezed because the shrinking pool of primary care providers is increasingly and quickly being absorbed by Health Maintenance Organizations and other managed care plans. Based on their growing needs, two national HMOs I know of could probably absorb all the family physicians produced this year. Rural and medically underserved communities need assistance to allow them to compete fairly for the providers they need.

Government, both state and federal, has the opportunity to pursue a number of strategies in order to address this shortage:

In the short-term, meaning the next five to seven years, we should work to decrease the existing gap between primary care providers and specialists in regard to federal payments under the Medicare and Medicaid programs. In addition, these programs should provide preferential reimbursement to primary care practitioners in medically needy areas, at least until the maldistribution of medical providers is equitably addressed.

As another interim step, public monies invested in medical school students could be tied to providing primary care services in medically underserved communities. The significant subsidy medical students receive (in federal and state funding) should somehow be tied to service. Medical school students receiving subsidies could be required to pay-back those subsidies in one of several forms such as 1) cash, 2) a debit to their State's Medicaid system, or 3) service in a medically needy community. We can no longer continue to invest millions of dollars in the education of students who choose to subspecialize in fields with a current oversupply and/or who locate in areas overpopulated with physicians.

Part of the solution lies in redirecting state and federal funding for health care training, currently in the form of Indirect and Direct Medical Education payments, Health Professions dollars, and all state funding of medical education. All of these dollars should be consolidated. These expenditures would flow through the State according to an approved State plan for health professionals that meets federal guidelines and criteria. These State plans would determine the types and number of residency slots, admission criteria and curriculum changes needed to achieve the State's objectives for health professional supply. The funds would reflect shared goals of federal and state governments, promote a balance of generalist and specialist providers and ensure an adequate distribution in rural and inner-city areas. Medical schools in States without approved plans would not be eligible for National Institutes of Health research grants.

In the long-term, given the increasing emphasis on preventive and managed care, primary care providers will be in greater demand. It is hoped that this increased demand will eventually close the gap between the incomes of generalist and specialist physicians. This dynamic may finally empower primary care providers, unlike the 1970s solution of building more medical schools, which did little to alleviate the shortage of primary care physicians. Already today in some markets where managed care plans dictate staffing patterns, subspecialists who cannot find work are being retrained in generalist medicine. Meanwhile, primary care physicians are in demand in almost all locations and can still choose to practice almost anywhere. More than any other factor, greater flexibility for practice location may become the strongest incentive yet for enticing young physicians to choose primary care.

The Need for Capital and the Development of Coordinated Care Networks

To move onto another area of concern, rural health systems are currently starved for capital funding. Under the present system, rural communities are either too small or too poor (or both) to compete in the finance market. Urban facilities have both the AA and AAA ratings and the savvy to maximize their opportunities. However, banks consider many rural facilities bad risks, and even the most savvy rural hospitals face high up-front administrative and legal costs that often make packaging bonds infeasible, given the small amount of funding sought. But the money is out there. Capital funding needed for rural projects is not significant when compared to the infusion of money into health care expenditures in this nation. I suggest three components to help rural communities compete for capital dollars:

- 1) Health Planning (at a minimum Facility Planning)
- 2) Certificate of Need laws (again, at a minimum for facilities)
- 3) Pooled Capital Funds (augmented by bond funds)

To achieve a balance, at least 50 percent of capital funding currently provided through Medicare and Medicaid should be earmarked for a central state fund and augmented through the sale of bonds. States are the logical administrators of this type of endeavor. States would distribute this funding based on a statewide plan that ensures that rural and inner-city facilities have fair access to capital to develop needed health care systems. In addition, States could use funding to develop Centers

of Excellence in medical care to promote high quality, high-technology care while controlling the proliferation of high-cost, high-tech medicine that increases costs.

The pooled funds could then be put to use to build the community-based, coordinated care networks that are needed in rural areas to maximize their health resources. Coordination and integration of services into networks must pass a **patient viability test**. This means that patients receive the care they need at the time they need it in a cost-effective manner—whether the care comes from a public health, primary care or tertiary care source.

To control costs, we must maximize coordination of services in rural areas as well as in urban areas. Facilities would not receive financing from the state pool based purely on need or their priority within the state plan. Rather, they would be required to show how their proposed project would be integrated into a sound health care network. For example, plans for a nursing home would need to be integrated into a local home health agency and other senior services. These networks and linkages, however, must ensure that patients are served appropriately and in a timely fashion and that quality care is maintained.

Managed Competition and Rural Choice

Managed competition offers rural communities an opportunity to enhance their health care systems. The final rules that regulate managed competition are critical to what happens in rural and inner-city areas. Thus, they have to be carefully crafted to ensure that the special dynamics of rural health professional, policy and capital resources are taken into account.

With only minimum regulation, highly-sophisticated centers of health care would likely gravitate toward urban areas in order to avoid the logistical problems of recruiting professionals or transporting patients. Rural communities are typically seen as nonlucrative markets and as a result may be given minimum investment.

At other extreme, over-regulation could lead to two equally disastrous outcomes in rural areas if rural residents are restricted to seeking care in their immediate area:

1) Over-regulation could form monopolies in rural communities that restrict consumer choice to one center of care, precluding travel to other urban or rural areas. 2) Another form of over-regulation could restrict rural residents to seeking care from local providers employed by large urban systems. Each of these urban systems may simply outstation a single physician or nonphysician primary care provider in a rural area who "compete" in a fragmented, unresponsive system.

The best vision is for "managed cooperation" that forces the development of a rational health care system in rural areas, one that maximizes scarce resources and encourages (even rewards) collaboration. Such a new system would enhance rural health.

The Essential Access Community Hospital Program

Finally, I wish to address the federal Essential Access Community Hospital Program. North Carolina is one of seven States participating in this program, and despite its slower than expected progress, we are very pleased to be one of the first States to implement this important federal rural health program.

I believe the EACH program will form an important foundation for the future of rural hospitals across this nation. Already, we have seen a significant change in how hospitals, physicians, other providers, public health departments, state agencies and hospital associations communicate. The mood is one of cooperation and communication that will, in the long run, improve community health systems. In fact, the EACH program would be enhanced if its emphasis on partnerships is

expanded even further.

I am hopeful that the technical amendments will further strengthen the EACH program. Although our progress has been slow, the direction is right. I believe all States should be allowed to participate, and more flexibility is needed to allow for multiple partners, both urban and rural. The EACH structure will complement health care reform, but many details need to be addressed to smooth out snags in the program. The prescriptive nature of the current regulations has already created several obstacles to the program's implementation. I have outlined a few suggested changes, which I believe could be handled through changes in the regulations:

1. The blood banking and availability requirements do not appear appropriate for many small Rural Primary Care Hospitals (RPCCHs). Administering blood is, in and of itself, a dangerous or life threatening procedure. Because blood and blood products require such strict practices, if the supply is to be stored and tested properly before being administered, even in emergency, it would be unwise to be specific as to how each RPCCH must do this or to say that all RPCCHs need to have blood available. There may be other ways to solve this emergency need, such as with plasma expanders. This single requirement also could push the RPCCH labs into the "high complexity" category under the Clinical Laboratory Improvement Amendments, at least as we can best interpret CLIA. The other lab requirements alone would appear to label RPCCH labs as "moderately complex."
2. The increased inclusion of rural areas into Metropolitan Statistical Areas needs to be considered for its impact on several programs important to rural hospitals struggling to survive, especially the EACH and swing bed programs. Neither of these programs may be available to rural hospitals included in MSAs. A system could be devised to qualify facilities in certain predominantly rural counties that are classified as MSAs because of commuting patterns or other criteria. Although these facilities could qualify for urban reimbursement, this added funding may not benefit some small hospitals or rural health systems as much as programs like EACH.
3. The EACH or Rural Referral Center hospitals should be given the choice of Sole Community Hospital reimbursement, not have it required.
4. RPCCH emergency rooms should be allowed to automatically refer to another ER after hours, if that ER is within 30 minutes and transport is available. Often, having a rational protocol in place for transfer makes more sense than requiring a RPCCH to call in staff to its ER within 30 minutes
5. I also recommend allowances for "grandfathering" so that EACH and RPCCH hospitals can maintain their status even if future changes in the law or other regulations disqualify them.
6. Finally, network development could be held up by potential anti-trust and fraud and abuse issues. There is evidence that provider concern with these issues has dampened interest in the program and other networking activities.

My over-riding recommendation to you is to grant more flexibility to the States. Following federal guidelines, the state agencies selected as leads for this program can serve as watchdogs to make certain that hospitals are living up to the national EACH standards while at the same time ensuring that limited local resources are used in a rational, cost-effective way that develops a sound health care system for rural communities.

Thank you again for your time and for this opportunity to come before you today.

Chairman STARK. Mr. McGrew.

STATEMENT OF CHARLES MCGREW, DIRECTOR, SECTION OF HEALTH FACILITY SERVICES AND SYSTEMS, ARKANSAS DEPARTMENT OF HEALTH

Mr. MCGREW. Mr. Chairman, members of the subcommittee, my name is Charles McGrew. I work for the Arkansas Department of Health. In that capacity I am responsible for those sections within the department that try to build infrastructure and work with health care systems development in rural areas, as well as underserved urban areas.

My written testimony is based primarily on a conference that was held in Little Rock in March sponsored by the Robert Wood Johnson Foundation and the Arkansas Department of Health. That conference focused on what we are talking about today on health care reform in rural areas. And those recommendations and cross-cutting themes are included in the written testimony, and your staff director has a copy of the full report. I would really encourage you to look at those. We had more than a hundred people from across the country who were experts in rural, all kinds of providers, rural health policy analysts, in a working environment with the concept.

Chairman STARK. Without objection, the report the gentleman refers to, we will put it in the record in its entirety. Thank you.

Mr. MCGREW. I appreciate that very much.

I would like to focus on three areas that are concerned not only from the conference with all the participants across the country but very much in the State of Arkansas.

And fairly recently when I was working in the State of Montana, you get into exactly the same issues. It has been talked about to some extent today.

I would like to emphasize the problem that we are going to have with providers. And my friend and colleague Jim Bernstein has just talked about the situation with physicians in training and adequate supply, redirecting our institutions to train an adequate supply of primary care physicians.

My concern is that not only do we have that 5 to 7 years to get things turned around a little bit, but we have a lag time of 10 to 15 years before we are going to have adequate family practice physicians available in States like Arkansas.

We are going to have to do some fairly radical changes at the State level, as well as those things at the national level that we have talked about, to make sure that we are putting our money into States in a way that will assure that they train the right kind of providers.

We also have not done a very good job with doing research and what it takes to get these providers into rural areas and underserved urban areas and to keep them over there over time. As matter of fact, we've done a dismal job with that.

The University of North Carolina is doing some excellent research right now, and they are about to publish some of that research. Some of the things have been sort of conventional wisdom about what it takes to get physicians out there and keep them

probably are not going to pan out quite as well as we thought that they would for those of us who have been in that field for a while.

The second issue, on manpower, that concerns me tremendously is we continue to talk about nurse practitioners and physicians assistants as a major part of the solution, especially in this transitional period for manpower in underserved areas. And we are making some real mistakes with those midlevel practitioners.

Number one, they are not generally available right now. Even though we talk about them in a lot—in my State, I can't hire them. We have got places all over the State of Arkansas that would love to hire a family nurse practitioner who is adequately trained. They don't exist.

In addition, training programs—

Chairman STARK. What do you pay a family practitioner physician, if you hire them on a salary? What is your starting salary?

Mr. MCGREW. A nurse practitioner?

Chairman STARK. No. For an M.D.

Mr. MCGREW. For an M.D., it is going to vary tremendously. Community health centers in the State right now are recruiting at up to \$120,000, plus a good fringe package for a family physician going into—

Chairman STARK. A beginning family physician, starting out?

Mr. MCGREW. Right. Nurse practitioners are commanding salaries in the \$40,000 to \$55,000 range, which, in rural communities in Arkansas, is an excellent salary for a nurse practitioner. But again, they simply don't exist. Health care reform as it is being proposed with network development and accountable health plans, I think, will actually exacerbate the problem for rural areas.

We are going to have urban networks that don't have adequate supplies of family physicians that will offer incentive packages that will pull physicians out of those communities into those urban systems.

So I think that, again, looking at how we are going to get down the road 15 years and hold the system together, it is critical that we look right now at incentives for medical schools and also ways to take nurses from communities that are underserved and get them back into those communities.

We are not doing that. We are not really looking at taking nurses from communities where they have ties, you know, they are going to be there over time, getting them into a good family nurse practitioner program and then back into that community. That is the way with nurse practitioners that you can retain them there. We know it works. We have done it with nurse midwives; we have done it with nurse practitioners. But in general that is not the concept that is being used by schools of nursing across the country right now.

And we are going to create a lot of nurse practitioners that will go into urban environments and not back into rural areas as we sort of think they will if we get more training out there. So we have really got to target how we do that training.

The last issue that I would like to touch on is the whole issue of the fragile infrastructure that we are dealing with with health care reform. Right now, in most rural States, and certainly in the

three that I worked in, you have a number of providers who are holding the system together.

If we don't assure that, that combination of folks—and in Arkansas right now I have got a coalition in one part of the State where we are trying to do some things with the infrastructure that includes community health centers, health departments, the university hospital, local hospitals, the major insurance carrier in the State, and an out-of-State hospital chain, that is—provides charity care as part of their mission. But unless you can get that combination of providers together and make sure that the fragile infrastructure that is there is maintained through at least this transitional period with health care reform, we are going to see things get, in the short-term, worse instead of better.

And that maintenance of that fragile infrastructure, I think, is absolutely critical. And I don't think it is getting enough attention as we struggle with health care reform and finance.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement and report previously referred to follow:]

**TESTIMONY OF CHARLES MCGREW
ARKANSAS DEPARTMENT OF HEALTH**

Mr. Chairman; Members of the Subcommittee:

My name is Charles McGrew; I am an employee of the Arkansas Department of Health. I am responsible for those organizational units within the Department that work with communities, providers, and other organizations to develop rural health services and rural health infrastructure.

My testimony today will be based primarily on issues and recommendations originating from an invitational conference titled "Health Care Reform in Rural Areas". The conference was held March 10-12, 1993, in Little Rock, Arkansas, and was sponsored by the Arkansas Department of Health and The Robert Wood Johnson Foundation.

The purpose of the conference was to develop a statement of the major issues and concerns which must be considered in developing health care reform for rural areas and to offer recommendations regarding the design and potential impact of such reform for consideration by the Administration and Congress.

The three major components of the conference -- informational presentations, panel discussions, and workgroups -- were designed to assist participants in shaping policy recommendations. Presentations by Alain Enthoven and Paul Ellwood provided an overview of managed competition and networks in health care reform. Lynn Etheredge and Dan Beauchamp followed with an overview of expenditure caps and global budgets. John Wennberg also discussed the potential roles of population-based health care planning and consumer choice in shaping a reformed health care system.

Conference participants met in the following eight workgroups: Service Areas, Supply of Human Resources, Networks Structure and Formation, Networks: Financing, Networks: Operations, Public Health, State Roles: Service Delivery/Network Formation, State Roles: Resource Allocation. The cross-cutting themes and recommendations in this summary were drawn from the reports developed by these workgroups.

A planning committee guided the development of the conference agenda, invitation list, and summary report. Members of the planning committee included: David S. Abernethy, Staff Director, Subcommittee on Ways and Means; Nancy L. Barrand, Senior Program Officer, The Robert Wood Johnson Foundation; James D. Bernstein, Director, North Carolina Office of Rural Health; Robert DeVries, Program Director, W.K. Kellogg Foundation; Donald F. Dickey, Program Officer, The Robert Wood Johnson Foundation; Linda Goldsmith, Director, Office of Rural Health, Arkansas Department of Health; Jeffrey Human, APSA Legislative Fellow, Senate Special Committee on Aging; Charles McGrew, Director of the Section of Health Facility Services and Systems, Arkansas Department of Health; Ira Moscovice, Ph.D., Professor and Associate Director of the Institute for Health Services Research, University of Minnesota; Dena S. Puskin, Sc.D., Acting Director of the Federal Office of Rural Health Policy; Sally K. Richardson, Director, West Virginia, Public Employees Insurance Agency; Steve Rosenberg, President, Rosenberg Associates; Robert T. Van Hook, Rural Health Consultant.

Within the thirteen recommendations, let me give special attention to recommendations number three, four, five, eight and nine.

Recommendations number three, four, and five deal with training and manpower issues that are absolutely critical to developing health care networks in both rural and underserved urban areas.

Recommendation number eight deals with protecting the fragile infrastructure in rural areas, an issue frequently ignored when competition is the base for health systems development.

Recommendation number nine focuses on the need to prevent extensive "opting-out".

I think you will find that these recommendations will provide valuable guidance in developing a health care reform proposal that will provide real access for our citizens in rural, frontier, and underserved urban areas.

CROSS-CUTTING THEMES

1. *Health care reform presents a critical opportunity for addressing fundamental problems in the rural health care delivery system.*

The rural health care delivery system is burdened by persistent problems that will require comprehensive solutions targeted not only at the financing, but also at the *delivery* of health care services. For example, there is an acute shortage of primary care providers in rural areas and many communities find it difficult to recruit and retain physicians and other health professionals. Small rural hospitals are more likely to be financially distressed than their urban counterparts. Rural residents are more likely to be uninsured. Furthermore, rural people must often travel long distances to health services and have more difficulty getting there. Fundamental to addressing such interrelated problems will be the development of the needed infrastructure and capacity for a fully functioning delivery system. Most important, health care reform must seek to increase and strengthen the supply of human resources in rural areas, provide appropriate incentives for network development, channel capital investment/resources where it is needed most, and allow flexible mechanisms for accommodating unique local circumstances.

2. *Flexibility and a range of options will be necessary for implementing health care reform in rural areas in order to meet diverse local needs and utilize local resources.*

Health care reform policies must be sensitive to the underlying dynamics and special needs of rural areas. The widely dispersed regions that we call "Rural America" are characterized by major differences in geography, natural resources, economic bases, and demographic compositions. In addition, state-by-state variation in facility regulations, health personnel certification/licensure requirements, and investments in health care training programs contribute to considerable differences in the capacity of local and regional health care systems. Both health care needs and resources can vary substantially from one rural community to another. Because of this tremendous diversity, states and communities will need an array of implementation options that they can use to restructure and strengthen their local health care delivery systems. Allowing for flexibility in the implementation of health care reform mechanisms will be vital to meeting the diverse needs of rural residents and attaining national goals for a reformed health care system.

3. *The active involvement of rural residents and the meaningful representation of rural communities at the state level will be essential to assure successful implementation of health care reform in rural areas.*

Many rural residents would be displeased with a national reform plan that came to their communities as an outside agenda developed by government leaders in Washington, DC. Physicians, hospital administrators, and other health professionals are integral to the social and economic fabric of rural communities. Many rural residents are also characterized by extreme independence and the desire to maintain control over their local institutions. Given the proper data, information, and an opportunity to consider their various options, however, residents in many rural communities have shown tremendous ingenuity and commitment in finding solutions to their health care delivery and financing problems. Because the extensive change under national health care reform will not come easily for many rural areas, it is critical that federal and state policy makers utilize the creative energy and resources of local communities to reshape the health care system that ultimately must serve their needs. Therefore, actively involving local residents and giving them the opportunity for meaningful participation in the development of regional and state health care policy will be essential to the success of health care reform in rural areas.

4. *The development of regional health care networks, which deliver primary care through locally-based providers, should be a fundamental strategy for restructuring rural health care delivery systems.*

Rural health networks have the potential for improving access to needed services, utilizing resources more efficiently, and strengthening the practice of medicine in rural areas. Guaranteeing financial access to a standard set of comprehensive health benefits will require providing geographic access to a range of primary, secondary, and tertiary services. Providing primary care and preventive services *locally* should be a priority, because family physicians and other primary care practitioners can meet the majority of health care needs that require a visit to a health care professional, and they generally use less costly equipment and technology. Regional networks would improve access to secondary and tertiary services that can not be provided efficiently by low-volume providers. Agreements among hospitals regarding consultations and patient transfers would assure access to surgical and specialty services provided at referral hospitals and tertiary care centers. The formation of such regional health networks will involve the creation of new organizational relationships, more extensive telecommunications linkages, and improved transportation systems among providers in multiple communities.

5. *Developing health care networks will require a variety of approaches from "managed competition" to "managed cooperation."*

It is unrealistic to think that a single model for network development can be implemented successfully in all rural areas. A range of implementation options and incentives -- from "managed competition" to "managed cooperation" -- will be needed to create networks that utilize existing resources most efficiently, build additional capacity where necessary, and meet the needs of vulnerable and underserved populations. "Managed competition" may be a useful approach for health care reform in some rural areas, such as those served by rural-based HMOs, having higher population densities, or located adjacent to urban markets. In such cases, competition may provide incentives for the more extensive and even more efficient delivery of services.

Providing incentives for cooperation and collaboration may be more appropriate for other areas, however, especially in sparsely populated areas, or where it has traditionally been difficult to recruit and retain health care personnel. To support practitioners in these rural areas, special efforts should be made to provide adequate back-up services, peer support, telecommunication linkages to hospitals in larger communities, and to arrange clinics with visiting specialists as needed. In many communities, special provider organizations -- including migrant health centers, community health centers, and rural health centers -- have been established to serve vulnerable and underserved populations. The investments made by the national, state, and local governments, as well as community-based organizations, in these types of facilities and organizations have been substantial. A cooperative approach to forming networks and appropriate financial incentives could help strengthen these vital entities.

6. *Dramatic changes will be needed to provide an adequate supply of primary care providers in rural areas.*

Health care reform as currently envisioned depends heavily on increasing the provision of primary care services. However, the supply of health care professionals who can provide these services is currently inadequate, especially in rural areas. Health care reform presents a critical opportunity for addressing this shortage in a systematic fashion. Graduate medical education must be reoriented to focus on primary care, and more primary care training and residency programs should be established in rural areas. Young people from rural areas should be encouraged and adequately prepared to enter the health professions. Barriers to practice must be removed for nurse practitioners, physician assistants, and nurse midwives. Reimbursement policies must be structured to compensate adequately primary care practitioners, both for their training and the time they spend with patients. Finally, additional recruitment and retention efforts are needed to assure that appropriate providers reach underserved areas and are supported once they begin practicing there.

7. *The health care infrastructure -- including people, structures, and systems -- needs to be strengthened in many rural areas to assure access to essential health care services.*

In many rural communities, the small population size, limited economic base, and a lack of trained personnel and organized systems have contributed to a weak health care infrastructure. Affordable capital financing is needed to renovate facilities and update equipment. Additional capital and human resources are needed particularly for improving transportation systems, upgrading and coordinating emergency medical services, and developing communications systems (e.g., teleradiology and compressed video linkages with referral hospitals). Besides increasing the supply of primary care providers, as noted above, other skilled professionals are needed to assure an adequate supply of managers, communications specialists, emergency medical personnel, and others. This will also require that educational programs are developed to train rural residents to perform these roles.

To guide system change, additional investments will be needed to build regional and state planning capabilities, including a data collection systems, analytic resources, and community education and decision-making structures.

8. *States should play a major role in implementing health care reform in rural areas.*

States will need to play a number of important roles under a national health care reform plan, especially to assure that the needs of rural residents are met. While the federal government should set the overall framework for health care reform, states must build on their traditional roles in health care to implement the plan (e.g., setting operational rules for risk-bearing organizations, regulating provider quality, providing coverage for their own employees, providing for the special needs of vulnerable populations, training health professionals, etc.). States are closer to local communities than the federal government, integrally tied to them through a system of elected officials, county commissioners, local social service agencies, public health departments, and other community leaders. Given sufficient resources and the flexibility to adapt national goals to meet unique local needs, states should be able to meet the needs of rural residents by: (1) assuring equitable access to capital, (2) training and promoting the appropriate distribution of health care personnel, (3) assisting communities with network development, (4) setting the geographic boundaries for health insurance purchasing cooperatives (HIPC's), and (5) assuring that vulnerable populations are adequately served.

RECOMMENDATIONS

1. *Define criteria for identifying areas where competition will or will not achieve the desired results.*

Given the fundamental concern that a "managed competition" strategy may not work in "non-competitive" rural health care markets as envisioned for urban and suburban markets, federal and state governments must develop criteria for identifying locations and conditions under which a competitively-based health care reform program is likely, or not likely, to achieve the desired goals. Such criteria could be used for determining distinct populations or geographic areas to be served by HIPCs, accountable health plans (AHPs), and where exclusive franchises might be given to AHPs and/or rural providers. These criteria would also be useful for health care planning and resource allocation purposes. As an illustration, workgroup number one on Health Care Service Areas outlined a five-tier typology of "regions for competition" ranging from "frontier," where competition would not be possible, to "major metropolitan," where full competition would be sustainable.

2. *States should have the responsibility for determining the geographic area served by HIPCs.*

If a managed competition framework is adopted for health care reform, states should be given the responsibility for determining the geographic areas to be served by HIPCs. Given states' interest and responsibility for guiding the allocation of health care resources, such control would be appropriate given the HIPC's function as a principle mechanism for pooling and allocating financial resources. States should be given the latitude to create sub-state regions for HIPC development, taking into account the boundaries of current health care markets, existing provider and network relationships, and the needs of vulnerable populations.

3. *Establish national and state health personnel policy goals and allocate training funds to assure adequate supply of primary care providers for rural areas.*

A health care reform program that appropriately places primary care and preventive services as its priority will increase the demand on an already limited supply of primary care providers in rural areas. To ensure an adequate supply of primary care providers, the number of family practice physicians and other primary care practitioners must be increased dramatically. It is imperative to establish national goals for the health professional workforce consistent with the general population needs and to allocate education and training dollars accordingly. In concert with these national goals, states should establish state-specific goals that take into account the needs of AHPs. States should also be given the authority to oversee the allocation of training resources so as to increase the supply of primary care providers serving in rural areas.

4. *Reorient medical education to focus on primary care and to provide clinical experience in rural practices.*

Graduate medical education (GME) must be restructured from its current hospital-based focus to include more ambulatory training sites in rural areas. Additional funding should be allocated to rural-based training programs for all levels of primary care professionals, including physicians, nurse practitioners, physician assistants, and certified nurse midwives.

5. *Provide strong incentives for states to adopt scope-of-practice laws with nationally recognized criteria that enable "midlevel" practitioners (e.g., nurse practitioners, physician assistants, certified nurse midwives) to practice semi-independently at sites remote from physician preceptors.*

If nurse practitioners, physician assistants, and certified nurse midwives are to be an important resource for improving the supply of practitioners in rural areas, it will be necessary to overcome the current state-by-state variation in certification and licensure requirements. Recognizing national certification standards and adopting appropriate scope-of-practice acts at the state level would remove inappropriate restrictions currently codified in law and improve the mobility of this important supply of personnel.

6. *To qualify as an AHP serving a rural region, plans must agree to make available the full range of services for all people in the designated geographic service area, providing the appropriate level of services — especially primary care and preventive services — through locally-based providers whenever feasible.*

Explicitly requiring AHPs to make available all of the services prescribed in the anticipated, national "standard benefit package" would increase access to a wider array of health care services for many rural residents. At a minimum, primary care and preventive services should be provided at the local level, with the understanding that in communities which cannot support a general hospital, such as those in sparsely populated areas, higher acuity inpatient services would be available at a regional referral center or an urban-based hospital.

One way to give priority to local providers would be to allow well-qualified rural practitioners (e.g., those who have completed residency programs and/or those who are board certified) to have the first option for "bidding" on contracts to serve their established markets. It may also be the case that such a priority status would give local providers the opportunity to establish rural-based AHPs or develop rural-based networks that selectively contract with suburban and urban-based providers for specialty care services. Such arrangements could help preserve existing doctor-patient relationships, as well as referral and collegial relationships already established by rural practitioners. In this way rural providers would be given the opportunity to take an active role in reforming and strengthening their community's health care system.

7. *Given the vulnerability of some rural providers, rules should be established to protect them from unreasonable financial risk.*

The imposition of "urban" provider risk sharing models that pass significantly higher financial risks to individual providers may force some rural practitioners to go out of business or move to other areas. If these providers leave, it may be difficult to replace them. Many rural solo practitioners and group practices in rural areas still operate outside of managed care systems and are inexperienced in dealing with the dynamics and financial incentives that drive HMO and PPO systems. There is a major concern that such rural providers may not readily adapt to capitated payment systems or those involving substantial performance-based "withhold" systems. Policymakers should be aware of this extremely sensitive issue.

8. *Some areas will require exclusive franchise arrangements for AHPs and/or provider networks serving rural areas.*

Where markets are "non-competitive," franchises should be granted whereby certain AHPs and/or providers are given an exclusive option of serving local residents. There are many questions about the ways such exclusive contracts should be structured and awarded. What time limits would be reasonable for giving local providers an exclusive option on serving their region, before opening the area up to outside provider groups? What discretion should local residents/consumers have in the development and monitoring of franchise agreements?

While franchises may be necessary in more remote, underserved, or vulnerable areas, it is not necessarily the case that this will be the dominant model in all rural areas. Again, a continuum of regulatory and financing options will be needed to accommodate the diverse range of local situations.

9. *Without the ability to include populations covered under Medicare, Medicaid, and the Federal Employees Health Benefits Program, many rural areas will have an inadequate population base to provide sufficient leverage on providers to participate in AHPs, or other provider arrangements under contract to the HIPC.*

Major policy decisions center on the issue of whether or not the financing resources for those currently covered under major federal programs (i.e., Medicare, Medicaid, and the Federal Employees Health Benefit Program) would flow into HIPCs and require these individuals to receive their care through the contracted AHPs or other arrangements made by the HIPCs. Because enrollees in these programs often constitute a large percentage of insured persons in rural areas, the prospect of rural providers "escaping" reforms by establishing specialized practices to serve mainly, or exclusively, exempted payer populations is particularly disturbing. If these major payers operate outside of the HIPC/AHP system, the desired competitive approach, where otherwise feasible, may be undermined in some rural areas. Given that such programs represent a significant proportion of provider revenues in rural areas, special attention to the impact of program exemptions and the payment policies of programs that are exempted is warranted.

10. *Rural providers opting out of AHPs should be subject to regulatory oversight on prices and capacity.*

As noted above, the question of whether providers would join an AHP must be considered in light of the alternatives available to them for opting out of such systems. Two scenarios would be possible: one is where providers can obtain sufficient income from payers exempted from HIPCs; the other is where providers choose to serve HIPC enrollees, but operate as solo-practitioners. It is generally believed that providers opting out of managed care systems that are under contract to the HIPC would need to be subject to regulatory oversight, such as rate regulation and controls on capital expenditures for plant and equipment, in order to assure compliance with cost containment and quality objectives.

The stringency of such price and capacity controls could provide strong incentives for AHP participation. Conversely, tight price controls on payments could jeopardize goals for recruitment and retention of rural providers, especially if prospects appear better elsewhere. Therefore, special attention should be given both to payment policies for health insurance

programs exempted from the HIPC and to the HIPC's policies for reimbursing providers who serve HIPC beneficiaries, but do not participate in an AHP.

11. *States should oversee the allocation of health care capital to support rural infrastructure development.*

Access to capital financing with affordable terms is a critical need facing rural health care providers with limited capital reserves. Older rural hospitals have a difficult time in maintaining and upgrading their plant and equipment, and both rural hospitals and physicians find it difficult to obtain newer and more advanced health care technologies. Rural communities with little or no established base of networked providers or alternative health plans will likely require greater capital investments to upgrade or convert their existing facilities and form network systems.

States should be given the authority for ensuring the availability of adequate capital resources and for allocating those resources so as to support appropriate levels of health care services in underserved rural areas. States would identify areas needing infusions of new capital and create mechanisms for channeling investment funds to them. Important sources of capital include state bonding authorities, Medicare capital payments, and the portions of payments made by other insurers or health plans to cover providers' capital expenses. Policymakers should be aware of the severe need for capital to build the rural health care infrastructure and how the financial incentives they create under health care reform will be vital to strengthening or weakening the capacity of rural providers to meet local health care needs.

12. *To ensure that antitrust laws are not an undue hinderance for rural network development, changes in federal and/or state statutes and supervision may be needed.*

Some believe that antitrust enforcement practices of the Department of Justice and the Federal Trade Commission have discouraged the formation of the kinds of joint ventures and other arrangements vital to network development. Others contend that antitrust rulings should have had little impact on collaborative relationships among hospitals and other providers. The extensive development of new networks that is anticipated, however, may require special attention by both federal and state law makers. One option would be modification of federal antitrust laws. An alternative would be for states to exercise "state action immunity" for arrangements it considers desirable, but which might otherwise be ruled unlawful under federal law. To create such an immunity, a state must both articulate its policy to allow a particular anticompetitive arrangement and adequately monitor and oversee the resulting organization/arrangement.

13. *Any national service program should place a priority on strengthening the infrastructure for rural health.*

Rural health care should be given priority under the development of any national service program that would attract college graduates and others into public service. Given that improving rural health care is a major national concern, any such program should seek to strengthen the supply of, not only health care professionals, but also managers, engineers, planners, and others vital to strengthening the rural health care infrastructure.

Chairman STARK. Mr. Linden.

STATEMENT OF TODD LINDEN, ADMINISTRATOR, GREENE COUNTY MEDICAL CENTER, JEFFERSON, IOWA

Mr. LINDEN. Mark Twain once said, "If I had known I was going to live this long, I would have taken better care of myself."

My name is Todd Linden. I am the administrator of Greene County Medical Center. It is a 127-bed hospital with 53 acute beds and 74 long-term care beds. Our town has 4,500 people; the service area has about 15,000.

I would like to thank you, Chairman Stark, for the invitation. I haven't read your legislation, but I am sure it is excellent. And I—

Mr. GRANDY. That comes in with no coaching by me, Mr. Chairman; an unsolicited endorsement.

Mr. LINDEN. I appreciate you allowing me to come and represent my community, talking about some of the issues facing health care.

I would also like to acknowledge Congressman Grandy. We certainly commend his leadership in the health care area here in Washington.

I am not going to read my testimony. It is there for you to look at. I would rather try to make use of this time to talk about some of the issues that are facing rural America and, perhaps as one of the last speakers, initiate discussion about what we might be able to do in rolling up our sleeves and meeting the health care needs of the rural communities out there.

The Twain quote is relevant because 22 percent of the population in Greene County is 65 years and older, 3 percent is 85 and older. In fact, Iowa, per capita, is the number one State in the country for 85 and older. And I think we fool ourselves if we are not thinking a little bit about when the baby boomers become senior boomers a few years from now.

You get a glimpse when you come to Greene County, Iowa, of what America is going to look like, beginning 15 years from now when these baby boomers come of age.

Meeting our community's needs is really our single credo. We are trying to figure out what our community needs regarding health care and trying to respond.

How do we do that?

We do that using our organizational structure. Our board is made up of publicly elected officials, so they are accountable to the community that they serve. The board has created a structure of committees—finance, quality assurance, strategic planning—that is made up of representatives of the board itself, the medical staff, but more importantly, also the community.

These community members come and tell us what our community needs are and help direct the board in terms of what we need to do.

So what have we done? One example of the needs we met was the development of what we call a hub and spoke for health care, with the acute care hospital at the center and spoke services around it.

Some examples focus on maximizing our facilities. We talked earlier about Hill-Burton funds. Some Hill-Burton funds helped create

the hospital with which I am involved. We try to maximize the resources that are already there.

The swing bed program, which I will thank this committee for helping to get through, has created opportunities for us to be much more efficient in utilizing those services. The same acute care bed can be used for observation care, for skilled care, for nursing home care, for whatever our community needs. And that has been real important for us.

Another example is in 1984, our public health department merged with the hospital. So we came together as health care professionals, collaborated; and now we can provide much more efficient care to our community that way.

We also provide well elderly clinics, immunizations, and school nurses. All those things are now available through this department with an emphasis on preventive care, keeping people healthy.

Another example is Health Enterprises Corp. This is a small company created by three hospitals in Iowa, including my hospital. It was created to buy equipment together so we don't duplicate equipment.

We bought cataract equipment; we moved it between the hospitals. And we are already creating a much more efficient, cost-effective way to continue to provide cataract surgery, which wasn't being reimbursed very well to the point we almost had to discontinue that service for our citizens.

I would like to expand on my testimony a little bit by talking about a couple of issues that are facing all of us. One of them is cost shifting. Without a doubt, cost shifting is the biggest single reason in Iowa for the rising cost of health care to the nonpublic sponsored patients.

Currently, this year, 78 percent of my patients are either Medicare or Medicaid. In February this year, 74 percent of the patients were Medicare, 13 percent of the patients were Medicaid; that is 87 percent. The other six patients, were nonpublic patients. Of those, half of them were bad debt or charity care.

Can you imagine trying to cost shift to three people? It just doesn't work.

What about the difference between charges and costs and all that sort of thing? In our case, jacking up charges just isn't an option. Even in lieu of competition, we are the only game in town. But increasing charges isn't an option. And that is because of the large number of Medicare patients that we serve.

In our 1992 cost report, the most recent cost report, our inpatient charges were \$1.5 million. Our inpatient costs, were \$1.7 million. So, our costs were much higher than our charges were. Reimbursement was \$1.4 million.

So what we try to do is create opportunities for helping our community generate resources which allows us to better meet the needs. We accepted the challenge in 1964 of the partnership with the Federal Government to provide health care to seniors. We haven't made money on Medicare for 15 years. And I think we have kept our end of trying to provide services to Medicare patients.

Let me try to summarize by talking about some of the concerns that I know this committee talks about from time to time: fraud and abuse, antitrust, physician referrals, things like that. In our

community, those are interesting kinds of issues because we all work together to try to meet community needs.

Antitrust issues, fraud and abuse issues, are very relevant for us because we certainly don't want to break laws; but we will do whatever is necessary to try to take the resources available to us and make them available to provide care to the seniors and other citizens of our community.

How do we do that today, when we don't know what reform is going to do? Well, we must look at the Medicare freeze and recognize that it will have a big impact on us. Regulation and trying to deal with regulation, fraud and abuse issues, prevention—there are lots of things we can do today short of major system reform that would allow us to better meet the needs of our community.

So, in summary, I hope I have been able to give you a brief description of what one real hospital and its community are attempting to do to continue to meet health care needs locally.

I am here today as a member of a special interest group. That is a special interest group, a hospital, that has a very special interest in meeting its community needs.

I need to conclude with a brief story. I was working on my testimony earlier this week in my office, and a housekeeper came in and was vacuuming. This is somebody that probably hasn't finished high school. He is a good employee, probably earns around \$5 an hour for the work that he does. And he said to me: "What are you doing?" And I told him I was working on testimony for this hearing. And he said, "Well, the other day I was watching C-SPAN." That caught my attention real quick when he mentioned that. And he said, "I was watching the Finance Committee of the Senate discussing the Medicare cuts." And he said, "I noticed that the voting was very partisan." And he said, "Which side are we on?" And that was extremely profound; one, that someone who makes \$5 an hour in a very small town in Iowa watches C-SPAN; and, second, that they understand very quickly that this isn't a partisan issue, this is an issue of providing care to the people of America and figuring out how to do it without wasting money and without creating serious problems for one part of the country while we fix other problems somewhere else.

Whatever you do, please help us create flexibility in our system so the local community can determine what its needs are and determine what resources it is willing to spend in order to meet health needs.

Again, thank you very much for the opportunity to testify before you today.

Chairman STARK. Thank you very much, Mr. Linden.

[The prepared statement and attachments follow:]

STATEMENT OF
TODD LINDEN, ADMINISTRATOR
GREENE COUNTY MEDICAL CENTER
BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ON
HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES

JUNE 24, 1993

Mark Twain once said, "If I'd known I was going to live this long, I'd have taken better care of myself."

Good Morning, my name is Todd Linden and I am the Administrator of Greene County Medical Center in Jefferson, Iowa. For the next few minutes, I will be telling you about the community care network that we are developing to meet the needs of our rural and rapidly aging population. I will explain to you why we have responded this way. And finally, I will tell you what key components of health care reform will be necessary to enable us to continue meeting the wide array of health care needs of the citizens in our service area.

Greene County Medical Center (GCMC) is a 127 bed facility with 53 acute beds and 74 long term care beds, in a county seat of 4,500 and serving a population base of about 15,000. My opening comment from Mark Twain is especially true for Greene County, with over 22% of our population 65 years of age and older, compared to 15.3% for Iowa and 12.6% for the United States. Over 3% of our population is 85 years of age and older, compared to 2% for Iowa, and 1.2% for the U.S. (Exhibit A). Keep in mind that Iowa ranks third nationally for 65 and older per capita and first in the nation 85 and older. This is relevant, because when looking at Greene County, Iowa, one gets a glimpse of the future American population structure, when today's baby boomers will become senior boomers a few short years from now. Of all people who have lived to age 65 in the history of the world, the fact is more than half of them are alive today!

First, let me explain for you what our strategy has been to meet the needs of our rural, aging citizenry. The key has been integration and collaboration. The concept is a simple hub and spoke design with the acute care hospital at the center and a set of integrated, health oriented services at the spokes (Exhibit B). Let me give you three quick examples of spoke services. In 1965, GCMC developed a 35 bed nursing home wing in response to the community need. Today, GCMC uses 85 of its 127 beds for long term care. Much of the overhead costs associated with an acute, inpatient facility are fixed regardless of the census. And maintenance of inpatient capacity in the community is essential. However, adding the very constant volume of nursing home care greatly spreads the overhead, creating much higher efficiency throughout the institution. In fact, we use our acute care beds for all levels of care, including: acute, skilled, intermediate, observation, hospice and nursing home care!

Another spoke in our network was added by the merger of the county public health department with the Greene County Medical Center in 1984. Once again, economy of scale efficiency was achieved and resources could be better allocated to meeting patient needs. All home health services we provide through this collaboration greatly improve the communication between and among staff, and better facilitates discharge planning and home care

follow-up needs. Well elderly clinics, immunizations, and school nursing are all provided through this department of the hospital with an emphasis on maintaining wellness and again efficiency by spreading overhead expenses.

Finally, Ever Greene Ridge is a recent example of taking the hub and spoke design one step further. This 33 unit retirement center located on the hospital campus opened in 1992. This public-private collaboration resulted in a winning combination for seniors, the community and GCMC. It is a "win" for seniors and the community in that it is a proactive facility, designed to foster independence and freedom for the seniors with the ultimate goal of extending independent living and reducing the need for institutionalization. Secondly, it is a "win" for the community because it adds to the tax base and has brought new seniors to Greene County (Economic Development). Finally, it is a "win" for GCMC in that we continue to meet community needs and at the same time add a service that adds to the efficiency of our operation. The hospital housekeeping, laundry, dietary and maintenance departments can be more fully utilized by providing services to seniors who are willing to pay for them, making the hospital once again more efficient. In addition, it puts GCMC one step closer to establishing a full continuum of care.

Let me move to a different kind of collaboration and integration of services that is currently underway involving the GCMC medical staff. With the hospital and doctors working together, new physicians have been recruited, new facilities and new services have been developed. Currently, the medical staff consists of five family practice physicians, two internal medicine specialists, one general surgeon, and one physician's assistant. However, it wasn't always this good. In the past eighteen months, GCMC has recruited to Jefferson two family physicians, one internist and a physician's assistant. What brought them was collaboration between the doctors, GCMC and the community. First, a new medical office building attached to the outpatient department of the hospital was constructed. This building, primarily built with donated funds, provides efficient and comfortable facilities which attracts both physicians and patients. The new clinic building is directly attached to the outpatient department of the hospital and therefore there is no reason for the physicians to duplicate lab and x-ray services in their office. The physicians and hospital shared in providing a financial package which, combined with extensive community involvement, culminated in the successful recruitment of scarce primary care professionals to Jefferson.

The physicians and hospital developed a rural outreach clinic in the small town of Bayard, staffed with the new physician's assistant. Primary care professionals, such as physician's assistants and nurse practitioners, are key to keeping access in rural areas. Medicare regulations are in need of revision to better allow for and pay for services provided by these professionals.

Finally, a \$350,000 donation by the physicians of their twenty-year old medical clinic building at the other end of the hospital campus was easily converted to a public health and education center.

The final three examples of collaboration and integration focus on working with other hospitals and technology.

First, Health Enterprises Corporation was formed between three hospital foundations in 1992. This small company purchased a set of mobile cataract surgery equipment that

was shared among the three hospitals. This joint purchase allowed the three hospitals to continue to provide this service to local patients despite reimbursement cuts which otherwise would have made the service costly to provide. Today, two sets of equipment now rotate to five hospitals to provide an excellent and cost-effective service to our patients without duplication and unnecessary capital expenditures by all five hospitals.

Second, the joint purchase of teleradiology equipment between GCMC and Trinity Regional Hospital in Fort Dodge has created better radiology coverage for GCMC when a radiologist is not present. This technology is taken a step further next month when GCMC and Iowa Methodist Medical Center in Des Moines will jointly demonstrate the capabilities of a statewide fiberoptics network. This interactive technology brings specialty services to the rural area for high quality, and cost effective care. Teleradiology, telepathology, tele-echocardiography, live patient consultation and interactive medical education are only a few of the revolutionary capabilities of fiberoptics (Exhibit C).

Third, Greene County Medical Center is a member of the Iowa Healthcare Executive Roundtable. The Roundtable is organized to improve educational opportunities for members; to facilitate broad-based research on health issues; and to study and undertake permissible collaborative ventures which aid the members in the discharge of their healthcare missions. Currently, the twelve members are discussing development of an accountable health plan. If developments of this nature are to be truly effective in improving access and quality, and reducing cost, special notice must be given to anti-trust issues. In rural areas especially, providers must be allowed to collaborate more extensively, even in the absence of competition.

So why did we do all these things? We did them to meet the needs of our community. But our job has continually been made more difficult because of tremendous underpayment by the Medicare program. Mere survival of access to primary care for our community and economic health as the largest employer in the county were threatened by inadequate payment by Medicare. I would be remiss and do an injustice to the seniors we serve, if I did not mention this major problem. Because of our high population of seniors, we average between 60 and 70 percent Medicare patients at GCMC. In February of this year, for example, GCMC's inpatient case mix was 93% Medicare and Medicaid. Cost shifting is not an option for us, when there are so few people to cost shift to. On average, we lose \$580 per Medicare case, the state average is over \$500 per case this year. Keep in mind "this is heaven, I mean Iowa" to paraphrase from the movie "Field of Dreams," where costs are consistently among the three lowest in the nation. Iowa currently ranks 49th of the 50 states in terms of average Medicare payments, with Iowa hospitals already losing more than \$73 million annually in the treatment of Medicare patients. GCMC expects to lose over \$ 1,462,000 to the Medicare and Medicaid program of total revenues of \$8,077,000 in the next fiscal year. (Exhibit D)

Further cuts or freezes in Medicare payment threaten all the innovative work we have done to keep our doors open and provide access to medical services for our service area. This system penalizes the most cost-effective providers and rewards high-cost institutions. A freeze for hospitals in Iowa, with such a large Medicare population, would be the death knell for many hospitals and do the exact opposite of what reform is all about. A Medicare freeze would reduce

access and drive patients to higher cost secondary and tertiary hospitals for primary care. Please remember in a few short years, all hospitals will have high Medicare case mixes, similar to GCMC, when the baby boomers come of age. The life expectancy of babies born today now exceeds 76 years.

I've told you what we've been successful at developing and why we've done it, now let me conclude with a few comments regarding reform and rural health care.

First, Medicare must be part of reform. Rural communities can't build networks unless the Medicare population is participating. Quality low cost providers must not be penalized by this system. States with high elderly populations must have opportunities to meet the needs of the citizenry. Without Medicare as a part of health care reform, rural health care is doomed and the health care crisis only deepens.

Second, regulation reform is necessary to reduce burdensome cost in the system. If the costs of the regulation outweigh the benefits to the citizens of the United States, get rid of the regulations. Time does not allow me to cite the many examples of over-regulation and duplication of regulation which has not done one bit of good in improving patient care, but has added greatly to the cost of providing health care.

Third, access to health care in rural areas is not necessarily assured by providing an insurance card to all citizens. Access by all citizens in Greene county is already in place. However, the current financing mechanism is threatening the current access despite quality service being delivered at low prices. The key here is my fourth point.

Fourth, make sure reform is flexible enough so that each state can develop the delivery system that best utilizes the resources available and meets the unique needs of the different areas of our country. A rigid system may solve one problem in one area while creating a new, different problem in another area. The local community must be empowered to develop the services needed and to use the resources they believe necessary to maintain and improve health. The community care network is the key to success in this area.

Fifth, a great emphasis must be placed on preventive health care. This is certainly not a new concept, (Exhibit E) however, it is time to get serious about smoking, high fat diets, lack of immunization, etc.

Sixth, reform must address the issue of consumer demand. It is pie-in-the-sky to believe we can achieve lower costs, while maintaining high quality, immediate and expanded access. Americans must be given an opportunity to share in the health care debate and discuss what the health care system should be expected to do and for what cost.

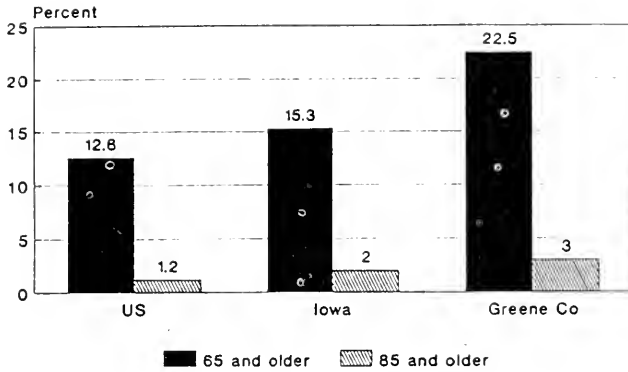
Finally, anti-trust issues must be addressed to allow continued collaboration in rural areas, so that cost-effective, quality care is available to all citizens.

In summary, I hope I have been able to give you a brief description of what one rural hospital and its community are attempting to do to continue to meet the health care needs locally. I am here today as a member of a special interest group, a hospital that has a very special interest in meeting the health care needs of its community. Truly, I am

here not representing GCMC, but the community our institution services. Health care is a major concern for our nation, and we must work together with diligence and trust, to meet the needs of rural citizens of this great nation, and I intend to be part of that solution.

EXHIBIT A

Population Comparison

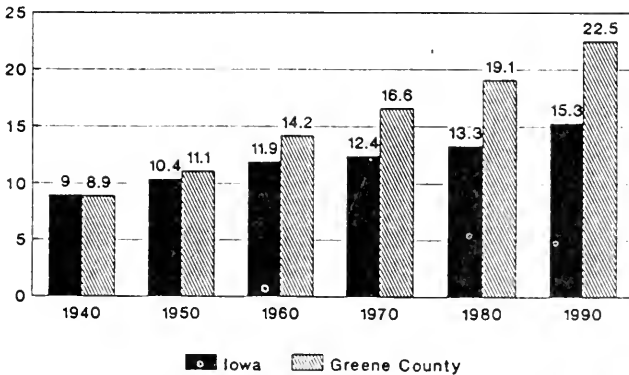


Median age

US 32.9 Iowa 34 Greene 40

Population 65 and older

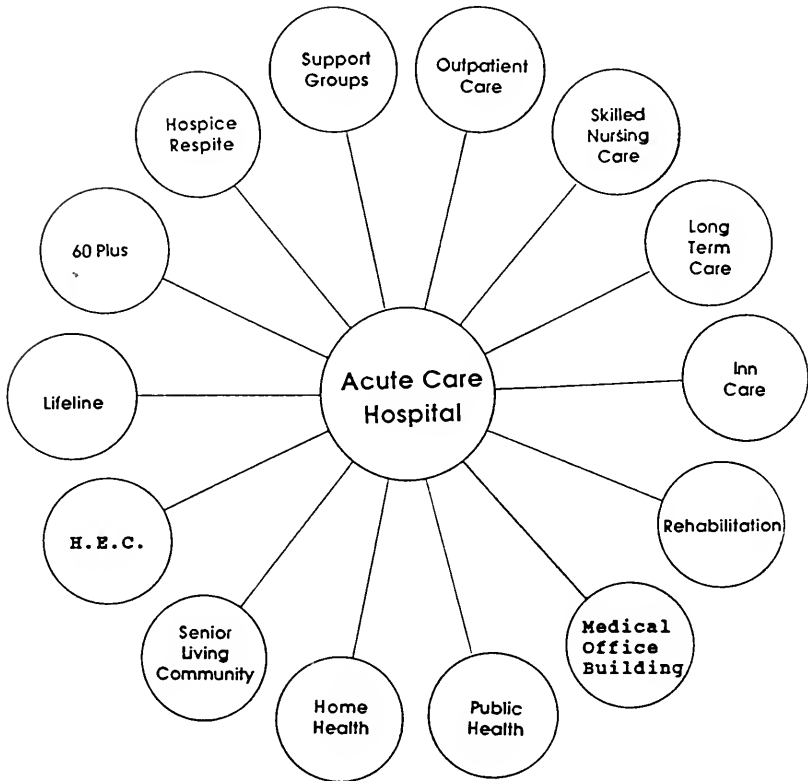
Percent population over 65 years of age



US 12.6% Iowa 15.3% Greene 22.5%

EXHIBIT B

GREENE COUNTY MEDICAL CENTER



GREENE COUNTY MEDICAL CENTER
 1000 West Lincolnway
 Jefferson, Iowa 50129

EXHIBIT C

THE DES MOINES REGISTER

June 14, 1993

Doing surgery over the phone

Doctors at the Greene County Medical Center and other rural hospitals soon may be able to get their patients examined — with a flick of a switch — by experts in Des Moines, Iowa City or even the Mayo Clinic in Rochester, Minn.

That switch, connected to a fiber-optic system that can transport video images, voices and information in nanoseconds, enables the small, rural clinic in Jefferson to bring experts into its examining rooms without anybody traveling anywhere.

Many rural hospitals see the hair-thin glass fiber-optic cable as their lifeline. By expanding their world using sophisticated technology, rural Iowa hospitals hope to accomplish one goal: keep patients at home.

Keeping them there will save them money and, in some cases, their lives, health-care officials say.

They will do it by holding two-way interactive teleconferences with specialists up to more than 100 miles away. Two physicians will be able to consult together with a patient as though they were all in the same room. Patients with difficult conditions can be diagnosed over the television screen, making a costly trip to an urban hospital unnecessary.

They will do it by transferring crystal clear X-rays, laboratory tests and medical records from one hospital to another to prevent duplicate testing if the patient must travel to another center for care. Or, for instance, an ultrasound test taken of a woman in Bloomfield can be viewed by a doctor in

Des Moines. In emergencies, information can be transferred in a matter of seconds rather than days.

They may even do it by teleconferencing live surgeries, in which national or world experts can coach Iowa surgeons via an interactive hook-up.

"The possibilities of fiber-optics use in health care are really endless," said Todd Linden, administrator of the Greene County Medical Center. "It could help people in rural areas where care is often more affordable right at the local level."

The Greene County Medical Center and larger, urban hospitals in Iowa are seeking

ways to turn the possibilities into realities. One avenue for the rural-urban hospital connection is through the Iowa Communications Network, the state-owned fiber-optic system that eventually will link most Iowa schools and government agencies.

Lobbying

Although only five hospitals have legislative approval to hook into the network during its final phase of construction next year, they are lobbying for more expansive use. Currently, the law would allow those hospitals to access the system only

Hospital officials say hooking up every health-care provider in the state — in addition to using the system for distance diagnostics and data transfer — will transform rural health care and possibly help avert a grim future. They see the ICN as the cheapest and quickest way to establish the most extensive medical network in the nation.

Despite opposition from the Iowa Telephone Association — which fears having to compete with the state for health-care business — the hospitals have had no problems getting vocal support from legislators for their plans. Although a bill permitting hospital use of the ICN for diagnostic services failed to pass this past session, officials expect the issue to resurface next year.

Meanwhile, the hospitals are struggling to find ways to pay for it.

The cost to each hospital for the necessary equipment is estimated at \$100,000 to \$160,000, said Perry Meyer, a vice president with the Iowa Hospital Association. "That's for all video equipment and everything that goes into it," he said.

Rural care centers could lower those costs to about \$25,000 for more basic services, he added.

Paying for Hook-Up

If state law is changed, hospitals likely will have to pay all the hook-up costs, unlike schools, which will pay 80 percent. The hospitals are looking to federal grants for assistance.

With the new federal proposal for the use of this kind of equipment is brought in several times," said Carmela Brown, vice president of corporate communications and government relations at Mercy Hospital Medical Center in Des Moines. "But Iowa is one of the few states that has it. So we will have a jump on every other state if we begin using this technology for everyday use."

Sen. Tom Harkin, D-Iowa, introduced a bill Thursday in the U.S. Senate that would provide money for hospitals seeking to form medical networks. The bill would establish three separate grants to help rural hospitals establish links with urban hospitals, help existing networks improve their systems or assist hospitals to hook up to a state-owned fiber-optic network, such as Iowa's.

"This technology will have as great an impact on medicine as X-ray machines and the discovery of penicillin," Harkin said while presenting the bill in the Senate. "And it will take rural health care into the 21st

Harkin cited some statistics while pointing out the need for the act. Eighteen Iowa counties now have no doctor and 14 more have only one. This year, 170 Iowa communities are seeking a physician. Telemedicine could help communities cope with the lack of health-care professionals while cutting down costs, he said.

Last year, \$1 million was appropriated for medical network pilot projects through Medicare administrative funds. The dollar figures for Harkin's proposal haven't been worked out yet, said Jodie Silverman, his spokeswoman.

Twenty-three hospitals affiliated with Mercy Hospital Medical Center in Des Moines and St. Joseph's Mercy Hospital in Mason City are trying to forge ahead with an interactive pilot project that may link the two hospitals to two other rural centers this fall, said Paul Maakestad, grants manager for the Mercy Foundation.

In a strange twist, the hospital consortium is meeting with telephone companies to do the pilot project over existing telephone facilities, rather than the state's fiber-optic network.

Maakestad said the pilot project will help determine exactly what kind of technology is needed and how to work it even before getting legislative approval to hook into the Iowa Communications Network.

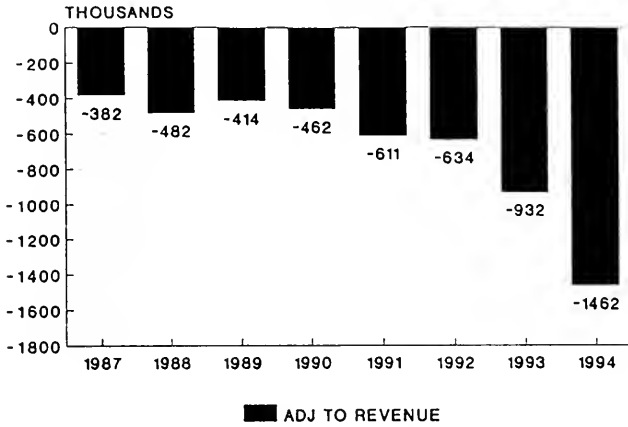
Asking for a Chance

Todd Schultz, legislative liaison with the Iowa Telephone Association, said the project gives telephone companies a chance to show that — even if the hospitals eventually do hook into ICN — they would like to be the companies to do the job. He added that the ITA is still opposed to the Legislature expanding the system to hospital use.

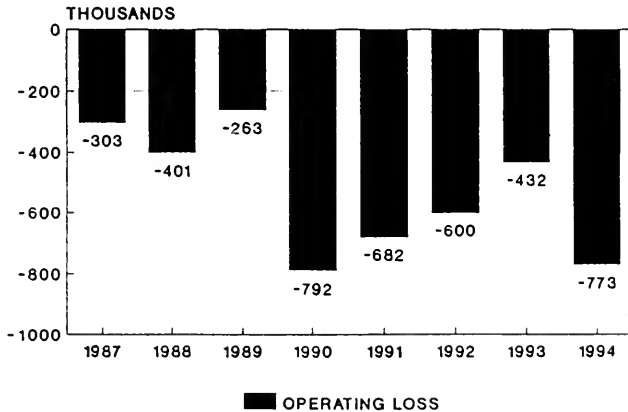
Mercy officials also have been talking with Iowa Methodist Medical Center in Des Moines and the University of Iowa Hospitals on how to develop standards for use of the system. In the future, hospitals would like to transmit electronic insurance claims and other paperwork to reduce hospitals' administrative costs through a fiber-optic system, said Ginny Wagner, director of physician and office systems at Iowa Methodist.

The talks started about two years ago, Wagner said.

"We've been pushing this," she said. "Our vision is way beyond what we're dealing with today."

EXHIBIT D**GREENE COUNTY MEDICAL CENTER FINANCIAL INFORMATION****Medicare/Medicaid Payment Shortfalls
1987-1994**

Footnotes: Fiscal Year 1993 and 1994 are estimated
 Fiscal Year 1994 assumes a Medicare freeze, no
 payroll increases, and a 10% price increase

**Operating Losses
1987-1994**

Footnotes: Fiscal Year 1993 and 1994 are estimated
 Fiscal Year 1994 assumes a Medicare freeze, no
 payroll increases, and a 10% price increase

EXHIBIT E

"Since both in importance and time, health precedes disease, so we ought to consider first how health may be preserved, and then how one may best cure disease."

Galen (Circa 170 AD)

Chairman STARK. Mr. Pawlowski.
Did I say that right?

**STATEMENT OF EUGENE P. PAWLOWSKI, PRESIDENT,
BLUEFIELD REGIONAL MEDICAL CENTER, BLUEFIELD, W. VA.**

MR. PAWLOWSKI. Pawlowski. Yes.

Chairman Stark, members of this committee, thank you very much for inviting me here today. I also have prepared statements which I will deviate from in my discussions.

First of all, I will be speaking today after serving for 2½ years on our Governor's commission for health care reform in West Virginia; and, number two, as chief executive officer of a health care system for the last 13 years.

To give you some background, in West Virginia we have just completed the progression of developing comprehensive health care reform. The people are ready for health care reform. They are expecting the government to help eliminate some of the fragmentation that we are seeing in the health care system.

In West Virginia we have the dubious honor of being ranked 50th as far as lifestyle goes. For 2 years in a row now, we have been rated as the lowest State in the country with lifestyle problems. Coupled with that, we are 43d as far as per capita spending.

In addition, we have found through surveys that our people are spending almost three times the dollars to prevent breakdowns in their cars than they are to prevent breakdowns in their systems. We are not putting time into prevention, or money.

When you look at our State, we have two extremes. We have most metropolitan areas that have excessive health care facilities, and we have those areas that have no health care services.

When you look in my own region, we have 150,000 population we serve. Within 15 miles of each facility, there are five acute care hospitals on the average of 12 years of age, and we are running 45 percent occupancy. Yet, two counties next to us have no health care services.

Within our region, we have seven rescue squads. On any one accident, you are going to have two or three of these squads show up. We do not have central dispatching or emergency 911 dispatching. We have too much technology in certain areas. We have no technology or services in others.

The reason for it, I think, is very simple. We have relied upon the competitive marketplace to allow our health care system to be driven. When you have a competitive marketplace, it doesn't work. When you look at the studies, when you talk to people, in a competitive market, you are going to do those things that will give the biggest return for that institution you serve. Therefore, money will be put into high tech services.

Yes, we are going to have two cancer treatment centers within 2 miles of each other, because there is money to be made in health care competition in that region. Therefore, if you rely upon a competitive model, you are going to have duplication in areas and underservices in other areas.

In health care reform, we need to have the local community participate in restructuring the system. We have found in West Virginia the best way to do it is let the community leaders sit in a

room, in an atmosphere where they have no fear of antitrust. We have—and I think it is an excellent model—we have completed in our county a West Virginia community care network model.

That model talks about how we can redistribute the resources, avoid duplication, provide emergency room services in the communities where it is needed. In effect, have different levels of the continuum of care model throughout the State.

One thing it requires is cooperation between providers to start developing community care networks. The annual savings just in my community between the two nonprofit hospitals are between \$1.5 to \$5 million. Everybody was excited about that, the ability to save money, the ability to take that money and start providing services in the outer reaches where we have nothing.

It all came to a stop because of antitrust litigation threats. When you have threats of antitrust, board members, community leaders, are not going to subject themselves to that kind of situation.

Some 120 miles away from us is the Roanoke Market Tertiary Care Center. In our region, that market spent \$3 million and had a tremendous amount of bad publicity—to do the same thing we tried to do, and that is cooperate to allocate resources.

They won. Make no mistake about it, they did win. But the bad press, the \$3 million spent in legal fees, is a deterrent for us to do it. So I think we are very fortunate in our region to have good facilities. But the fact remains we are really wasting money and resources providing too much and other parts of our State are not receiving health care services.

We have to get to a cooperative model where we can start working together, talking about, not the institution, not the particular doctor, but the population in total. We need to start getting back to defining that we are in the business for the population, for the patient; and we don't wait until the person shows up in the emergency room with a major cardiac or cancer problem. But we need to start at the front end doing more, wellness, prevention, and primary care.

It is great to say we need more primary care; but just like these gentlemen said, there are no primary care doctors available to come out in the communities. Every county in West Virginia has an extreme shortage of primary care physicians. Physicians are hard to come by, especially in the primary care markets. And they do cluster in your urban areas where they have a more positive lifestyle.

So whatever you do, in addition to antitrust relief, we need to look at how we can restructure the educational system and get more primary care practitioners in to make a lifestyle change so we get early detection, early prevention.

So thank you very much for the opportunity.

[The prepared statement follows:]

TESTIMONY
OF
MR. EUGENE P. PAWLOWSKI
PRESIDENT, BLUEFIELD REGIONAL MEDICAL CENTER
SUBMITTED TO THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH

Thank you Chairman Stark and members of the House Ways and Means Health Subcommittee for the opportunity to discuss with you today, issues relating to the delivery of health care services in rural communities.

I am the President of Bluefield regional Medical Center, a 265 bed non-profit community hospital in southern West Virginia. As the area's largest health care provider in addition to being a center for cardiology, cancer treatment, comprehensive wellness, and obstetrics, we serve a rural coverage area spanning over five counties, where approximately 150,000 people reside.

We, like most rural communities in this country, are fighting to improve both the quality and accessibility of health care. As you have stated previously Chairman Stark, this is a problem in both rural and urban America.

Last month, I testified before a subcommittee chaired by our State's great Senator, Jay Rockefeller. For two hours I listened to testimony from lobbyists who never once mentioned, let alone championed the needs of the health care consumer. I believe the problem is that these groups have forgotten that there is only one reason for the existence of health care providers; and that is to provide for the well being of the residents of our communities.

Today, I come to you not only as the president of Bluefield Regional Medical Center, but also as a representative of the thousands of patients who use our services every day, and the many thousands of residents who can't afford, or can't get to health care services, but should be receiving it.

We are not the only health care provider in the area. Princeton Community hospital, a 211 bed acute care system; St. Luke's hospital, a 79 bed acute care for-profit Galen owned hospital, Tazewell Community hospital, a 56 bed acute care facility, and 65 bed Giles Memorial Hospital, are all within 15 miles of each other. In addition, approximately seven home health agencies also operate in the five county region.

The greatest obstacle to real health care reform in our region and throughout the country as I see it, is a competitive relationship between health care facilities and services that places the health of the institution above the requirements of the patient. Our geographic area is saddled with an overabundance of high tech equipment and facilities that are under-utilized; there are 3 MRI units in the area, 2 lithotripters, two comprehensive cancer centers, and occupancy rates that average below 50 percent. Our area has seven different rescue squads, all competing for market share, yet due to fear of anti-trust, there is no central dispatch for these squads. Emergency rooms have no control over the timeliness and flow of patients that are transported, or the prioritization of transport, and as a result, a patient that might need us first, may not get to us in time. Another disturbing reality is that approximately 70 percent of patient visits to our over-utilized emergency rooms in the region could be handled by primary care centers which would be dramatically more cost effective than emergency services and at the same time make ERs more efficient by easing overcrowding. Yet there are two counties in southern West Virginia that do not have health care facilities, doctors, or rescue squads to provide basic primary care in life threatening situations, to their residents.

This justifiable fear of anti-trust violation and the market competitive health care environment held over from the 1960's continues to make health care institutions prioritize competitive viability rather than collaboration. As a result, we have duplication of high profit—high tech services, and shortages of so called "unprofitable" programs, such as primary care, wellness education, and prevention and early detection of disease through regularly scheduled health care screening programs. Through collaboration, we must seek to more rationally allocate the use of high-tech and specialized care based on community need, and not on market share.

Unlike facilities in urban areas, Bluefield Regional Medical Center's service region includes sparsely populated, remote areas that are difficult to access from Bluefield and Princeton, the two largest communities in the region. As a result of this reality, it has been important that our facility develop and provide a full spectrum of health care services for our service area.

With this commitment in mind, Bluefield Regional Medical Center owns and operates a 120 bed nursing home, and a comprehensive Wellness Center. The hospital also manages a Physician support network with the primary goal of attracting and keeping high quality doctors in our region.

One of the first programs we designed with the community rather than the institution in mind, centered around our Wellness Center and our corporate wellness program. More than 12 years ago, Bluefield Regional Medical Center saw the need to initiate the development of programs that would encourage through the participation and encouragement of area employers — the active participation of employees in individual wellness programs and positive lifestyle management. Over the years, our employees and thousands of others from throughout the region have participated in programs such as Smoking Cessation, Stress Management, proper diet, and others. Preventive wellness programs include risk assessment evaluations, resulting in individually tailored wellness programs. These programs are developed based upon age, family history, work habits, use of tobacco and alcohol, exercise habits, nutrition, access to preventive services, and other factors, with the goal being to educate the individual to develop a lasting, healthy, lifestyle. It should be noted here that our state has ranked as the most "unhealthy" state in the union by a nationwide insurance carrier for two years now, so I believe that it would be safe to say that the need for wellness programs in our area is more than significant.

In addition, we advise through these programs the provision of wellness incentives to employees, and encourage employers to actively participate in monitoring and controlling employee health. Because of our commitment to wellness, Bluefield Regional Medical Center was recently awarded a twelve month grant by the State of West Virginia to work with up to 27,000 state workers on wellness and preventive health programs through assessment, education, incentives, and disincentives. The motivation is obvious — Healthy employees contribute to the well being of the community, and the well being of the community is the goal of the health care provider. Wellness programs are working in southern West Virginia, and I respectfully encourage you to support such programs throughout rural America.

Still, nothing is more paramount than the accessibility of physicians to rural patients. In southern West Virginia, we fight this battle every day. As I'm sure you understand, it is difficult to retain physicians in rural areas. The pay is less, the hours are longer, and the support network just isn't there. Support networks in rural areas would require collaboration from providers that now compete, and are hesitant to cooperate, fearing repercussions of antitrust. In addition, Safe Harbors regulations, which providers had hoped would assist in the interpretation of Medicare/Medicaid anti fraud statutes, have left much to be explained about the law. As a result, our area physician recruiters remain apprehensive as they still speculate about what they can possibly do to compete for quality doctors. Even with that in mind, Bluefield Regional Medical Center and other rural providers still work tirelessly within these constraints to attract not only qualified physicians, but the proper "mix" of physicians, to our area.

Currently, our hospital has a full time physician recruiter on staff, who works with community leaders and our resident physicians on plans involving the enlistment of physicians, retention of our current medical staff, and provisions for the replacement of physicians nearing retirement.

Our physician support group helps doctors keep down ever increasing operational costs by providing assistance in the areas of accounts receivable, electronic billing for more than 100 commercial carriers, Medicaid, Medicare, hiring and training of personnel, and much more. We also provide educational programs designed to provide our physicians, especially our primary care doctors, updates on new technology and education. We hope that by providing these support systems, physicians will continue to practice, and even expand services, within our region.

Additionally, and as a matter of moral responsibility, Bluefield Regional Medical Center has been an active supporter of a local primary care organization called Mercer County Health Right. This group of dedicated volunteers provides free health care services to the poor and disadvantaged in our area, relying primarily on grants, and other contributions. With more than four thousand patient contacts each year, there never seems to be enough time in the day for these individuals to care for the sick. To assist in their efforts, Bluefield Regional Medical Center donates the services of an emergency room physician. We also handle all referrals to our hospital should the need arise. We see this as one way of helping the community, but in another sense, it also alleviates an additional burden on our emergency room. Once again I would like to recall that 70 percent of all emergency room visits can be treated at primary care facilities.

There's More.

Even with these types of support programs, it has become apparent that physicians are still reluctant to relocate to the outlying, less densely populated regions. Therefore, Bluefield Regional Medical Center is currently designing a program that provides the same type of support for primary care clinics.

Recently, through the efforts, management skills, and resources at the hospital level, we were able to help a rural clinic experiencing serious financial and management difficulties. A small county medical clinic, in neighboring Virginia, faced losing qualification for a sustaining grant through the Department of Health and Human Resources, and was in jeopardy of closing down. Through a cooperative venture, we helped the clinic hire a consultant who specialized in these types of grants. In addition, the hospital provided assistance with accounts receivables, purchasing, and other services that we routinely provide our own physician network. As a result of these efforts, the clinic was able to save thousands of dollars through cost controls.

That may not sound like a lot of money, but in many rural areas, a few thousand dollars is the difference between an open clinic and a closed one. More importantly, this county medical clinic began a very important relationship with Bluefield Regional Medical Center — One that benefits them through the sharing of educational tools, the purchase of materials and services, and the recruitment of doctors.

Because of this special relationship, Bluefield Regional Medical Center bought and renovated, and then leased back to the clinic, one of the buildings that the clinic currently operates out of. This has helped to keep their overhead low, but still provide a much needed service to the community. Originally that county did not have one single doctor. It was through the collaborated efforts of our hospital, and the local community, that two physicians now operate at two clinic sites to serve area patients. As this story illustrates, it is through collaboration, not duplication or competition, that we can help bring down the cost of health care...and begin to use those saved dollars to make these services available to those who need it in their communities. In fact, the West Virginia Health Care Commission, created by our governor Gaston Caperton, and of which I am a member, recently documented between \$1.5 — \$5 million in potential savings that could be achieved if only two of the area hospitals in our region would work together to reduce duplication.

Maybe that's not much to Washington insiders, but the prospect of nearly \$5 million in annual savings multiplied by the many communities throughout this country is phenomenal.

We presented the Commission's findings to community leaders, who were excited about the savings. Our board of directors and the medical community also became interested. We created a coalition involving the two non-profit hospitals and community leaders. The community said "great, lets talk about how we can all work together."

But that's where the problems began. The for-profit hospital in our region threatened legal action "both personally and organizationally" if we ever met again. Let me tell you, that kind of threat creates a lot of difficulty for business leaders, many of whom serve on hospital boards voluntarily and receive no compensation for their long hours of work. Because of this threat, all efforts at collaborative planning have been halted, and sadly for our community, no new action will be planned until we can come together without fear.

All of the attorneys we consulted said "yes, you could possibly win, but the cost, the effort, and the possible negative publicity could hurt your institution." Our attorneys continue to remind us of the recent bad press and expense that Carilion Health Services, just 100 miles from our hospital experienced; they spent more than three million dollars in legal fees to successfully fight anti-trust issues. Yes, they won, but at great expense to their health care delivery system and the people that they serve. Obviously, our community is somewhat frightened of the effects that a lawsuit might have on our health care system. So, the price of healthcare continues to rise in the name of competition.

It is my personal belief that collaboration, such as what was done with that small county medical clinic, is the only way rural communities can continue to provide and expand their health care services.

I ask you to review our anti-trust laws so that we, as providers, may sit down together and talk about how to reduce the enormous duplication in services, and to use those savings to provide proper access to all in our area without fear.

We need to make fundamental changes to our health care system in order to improve the health of our population, contain costs, provide universal access & coverage; emphasize prevention, early detection and primary care, and provide for a more rational allocation and use of high-tech and specialized care.

Mr. Chairman, members of the committee, I commend you on your interest in rural health care.

Chairman STARK. Thank you, Mr. Pawlowski.

It isn't often that we hear about rural communities with an excess of high tech equipment. That is interesting testimony.

And on my first question—I am not sure that Mr. McGrew doesn't have to excuse himself—but I would like a little straw poll here. You are all familiar with Medicare and you are familiar with Medicaid. As providers—and this is purely hypothetical—but if you had to choose between the two systems as your sole source payment system, how many of you would choose Medicaid?

Mr. Bernstein, do you run it in your State?

Mr. BERNSTEIN. No.

Chairman STARK. OK. How many of you would choose Medicare?

Am I correct in assuming that all but Mr. Bernstein would prefer Medicare over Medicaid?

Mr. PAWLOWSKI. Correct.

Chairman STARK. The reason I ask the question is because, Mr. Linden, you mentioned that we must involve the Medicare system in reform. And many people are suggesting we must allow the States to run the programs.

And I guess what I have trouble squaring is that throughout the country I have a hunch that 48 out of 50 States would tell me that they, if they had to choose, would prefer Medicare over the Medicaid system. Why should it be any different in health care reform? Why suddenly should my State, let's say, where the Medicaid system is in disarray—I don't want to get into any of yours—Mr. Bernstein has defended the system he runs. I would think Mr. McGrew does, too. But maybe his boss isn't listening.

Is there anything so magic about what all of your States have on the shelf that they are just about to produce in the way of legislation that is going to solve the problems of the delivery system in your States?

Does anybody have some secret weapon they are about to unleash on it or on us?

And I don't make my brief comment, mind you, to suggest that the Federal Government necessarily ought to run a system. But I would phrase the question this way, and the record can't show your kind of sullen nods as response to that question.

But would you all be content if, as we initially work out some reform system with the Federal Government, whatever the minimum benefit package is, leave you the option at any time that you felt you could provide it better, then go ahead and do it, as Maryland does, say, with their hospital system?

Would you all be comfortable with that sort of an approach?

Mr. Linden.

Mr. LINDEN. Well, my first reaction, of course, is it would scare me to death to have the Federal Government have all of the payment power—

Chairman STARK. Beg your pardon.

Mr. LINDEN. It would scare me to death to have all of the payment programs coming through the Federal Government from the standpoint that that is the single biggest source of our problem—

Chairman STARK. Let's say we let all the insured, the people in some kind of a program now, but let's just say many Iowans are

uninsured and say, "OK, we are going to have a system that takes these people and provides care for them."

Mr. LINDEN. Sure.

Chairman STARK. Let them go into whatever systems you have in Iowa. At some point, somebody has got to bell the cat. I mean, either the Governor of Iowa has to come out—well, the new Governor may take care of this much better, but either the Governor of Iowa has to come out and get a plan through the Iowa State Legislature, or I suspect the Federal Government has to be the fall-back.

We are not jumping up and down to run off and take on this challenge, certainly not for everybody in the country, but we get into a lot of discussions here on our committee, where we hear the States have to be able to do it. The States have to have the flexibility to do it, and I guess what I am asking is, are your legislatures champing on the bit to get in there and run a system and would they agree any faster?

Would you have any less gridlock on the average than we have back here?

Mr. Pawlowski, go ahead.

Mr. PAWLOWSKI. I think in our State we spent 2½ years on a commission. We have an excellent report that talks about all the comprehensive reform necessary. We ran into more gridlock on the State level because I think part-time State legislative people have less knowledge of health care reform than you do with your hearings up here.

The Medicaid problem I think is a little bit different than reform. Medicaid is really a funding difficulty the State has and every legislative person has to make a decision, "Do I put more money into Medicare or into education?"

Chairman STARK. Governor Wilson is a great guy, but the minute he has to deal with a whole bunch of constituencies—and poor people tend to make up the large part of our uninsured in California—he has a lot of pressures and the State of California quite frankly doesn't have any money.

I don't suppose the State of West Virginia is very flush either. I would assume that we are not violating a lot of States' rights, and some of you come from States where the history of the conservative States' rights is much more embedded than it is in California, and I am just trying to say, imperfectly—I have no quarrel with the State that wants to take it on, but I want to hear the case that we should stay out completely.

Mr. Bernstein is going to make that case.

Mr. BERNSTEIN. No, I am going to change my vote. I was interpreting your question a little bit more narrowly. In the larger sense, I don't think, if you get a few States that are going to do what you are talking about, you probably could get a few. I don't think you are going to get—

Chairman STARK. Vermont, Hawaii, and New York possibly.

Mr. BERNSTEIN. Maybe. So I agree with you. Personally I think that all the funds should be pooled and theoretically taken out of a general fund up here. Now, how they get distributed and spent is a whole different story, but I don't see why a State with a large

percentage of poor uninsured should be discriminated against a wealthier State.

The only way you are going to get over that is for the Federal Government to pool all the funding.

Mr. PAWLOWSKI. I have a comment, too. We have Bluefield, W. Va., and Bluefield, Va. We are on the border right now, and we are having differences in State reimbursement, State malpractice, State tort reform. What you have is doctors and providers going from State to State and it is causing a major fragmentation.

We don't even look at the market down there as far as States, but yet we have doctors living in Virginia because of malpractice and economics, and the facility is in West Virginia. So if you don't do it nationwide, then every border community is going to have difficulty in trying to treat two different populations.

Mr. LINDEN. Mr. Chairman?

Chairman STARK. Yes.

Mr. LINDEN. Just to finish my comment, the incentive under the Medicare program is appropriate. The only time our hospital makes money is when a patient is admitted and dies immediately. It seems to me that what we need to do—whether it is a governmental payer system or something like that—is to improve the incentives for the delivery of the care. I wouldn't have a problem with what you are talking about as long as we make sure that the current risk of taking care of Medicare patients is balanced and we have enough non-Medicare patients to shift the cost to in order to make it break even.

Chairman STARK. Let me try this: You are 80 percent Medicare?

Mr. LINDEN. Up to, yes.

Chairman STARK. If you got Medicare rates for your Medicaid population and no uncompensated or charity care, and you got the Medicare rate for everybody who came through the door so you would end the concomitant savings in your bookkeeping department of a single payer, could you survive? No uncompensated care, Medicare rates for the Medicare patients, and single format billing.

Mr. LINDEN. We would survive as long as the local community continued to provide additional tax support and donations. If it was simply based on the current payment mechanism, no, we would not survive.

Chairman STARK. Anybody else who runs a hospital or a system?

Mr. Whitten.

Mr. WHITTEN. Not from a hospital's standpoint, but we have the same situation from a community health center standpoint. Without that kind of subsidization, you can't provide the services and the outreach and so forth that are necessary to bring those people into the center. You just can't do it.

Mr. PAWLOWSKI. We subsidize our awareness program from our high tech services. There is no question about it. The incentive has to be changed where the reimbursement system should be spending money at the front end for wellness and not at the back end for high tech, heart attack, catheterization.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

It seems to me, gentlemen, that you and a lot of the people that have testified on other committees to help us understand what the

enlightened Federal-State relationship ought to be on health care delivery, the consensus seems to come down that most States—whether they are representing these States or they are providers within the State—want to see some kind of Federal guidance in defining what the benefit should be or guidelines to that effect, and they want the Federal Government to set up the financing system. I think you said this, Mr. Linden, that we were talking about your community support.

Health care in most cases is like what Tip O'Neill said about politics. It is all local. In many cases it is personal. So you want the delivery systems to be held as closely in the community and, if necessary, in the State as possible.

Now, that is a tricky piece of business, and I think what the chairman was getting at is what is the best way to do that. We have several huge Federal programs right now which would have to be considered in any kind of enlightened network, but I want to go back to some of the stuff you talked about.

A fairly large chunk of your reimbursement comes from the Federal Government right now and with it comes, in many cases, punitive regulations and impediments to delivering care. How do we, if we can set up a Federal mechanism, if we can provide a benefit that we can all agree to, how do we make your work easier by either providing broader guidelines, more supervision, and fewer regulations to make these community delivery systems work without becoming terribly expensive?

Somewhere we have got to contain costs, too. That is a large part of our problem and a major consideration at the administration.

Mr. LINDEN. You hit on a very key point. I think we are in the 60-minute syndrome where in terms of regulation there is a very acute problem somewhere that is globally identified and then we create some regulations that add all kinds of burden to the rest of the system that maybe doesn't have that very acute problem that was identified in one place.

We do need regulation, but let me give you just a quick example. In 1992 this happened at Greene County Medical Center. I brought with me just a file. These are the reviewers that came to our hospital during 1992.

The joint commission, which of course we invite to come and be part of our survey, but then the State did a validation survey on the joint commission. The Federal surveyors decided to do a validation study on the State, and then the State came back to follow up what the Federal Government found in their survey. As an example, one of the Federal surveyors in her exit interview was talking about one of our long-term care residents. She had asked her if she had voted in the Presidential election. She said no and the surveyor asked her why not.

She said, "Well, I didn't really understand the issues." We were cited by the Federal Government for not being proactive enough to have recognized that she didn't understand the issues and that we should have provided some format for helping her understand the issues so she could be an informed voter.

I asked the surveyor if she understood the issues in the last Presidential election, which she got angry with me about—

Mr. GRANDY. Cited you again probably.

Mr. LINDEN. Well, I turned my pager on to beep myself out of the room because I was getting so angry I knew I was going to cause more problems than I was going to solve. But the point is, that we really do need to look at regulation. Certainly there needs to be a certain level of regulation, but we have lost sight of the cost and benefit of regulation.

Mr. GRANDY. That is a real, I think, important point. The whole cost benefit ratio here. One of the fights that we have had, particularly when we were debating the Medicare freeze in this subcommittee prior to the reconciliation discussion in the full committee, was whether or not we should expand the opportunities and availability of nurse practitioners.

The argument against it—I carried the amendment, it was not agreed to—is that there is an opportunity for abuse. There is an opportunity to rip off taxpayers. Yet I think I heard almost every one of you say there is an important midlevel practitioner in your health care networks. How do we thread that needle? If we put these people in the system, how do we supervise them, set them loose, but make sure we don't overregulate them out of the system, but also protect taxpayers and patients?

To some extent, we are going to have to trust you people in the trenches; isn't that correct?

Mr. LINDEN. That is absolutely the key, Congressman. We have to get back to a level that as Americans we trust each other to a certain level to do the right thing, and I know that is difficult because we do have, unfortunately, the media that is often looking for the one or two or three bad apples that create such a misunderstanding in our communities, and I think that we have to come back to a certain level of trust.

There has got to be accountability, but it comes down to trusting each other.

Mr. GRANDY. Well, taking a variation on what the chairman is talking about, possibly creating a system where perhaps Medicare and Medicaid were more federalized and incorporated and perhaps even blended into a benefit package for people who are not enjoying direct Federal subsidies now, do you see yourselves being able to provide that, or are you worried that the oversight mechanism would be greater than it is now and there would be greater HCFAs and greater CLIAs and more supervision, or is there a way to, again, provide the funding mechanism, the basic benefit guideline and turn you folks loose and save some money in the system?

Anybody can answer that. I am not just directing these to Mr. Linden.

Mr. MCGREW. I probably shouldn't mention this, but I am going to and it is certainly not something I would recommend for most States. I am responsible for health care regulation in the State as well as infrastructure development. Again, and it absolutely would not work, and I wouldn't recommend it at all, but it makes for a fascinating interplay, and the theory was, when this section was put together that I direct, that if we were looking at our regulations at the same time we were working with communities and providers and trying to make the system work and develop infrastructure, then our regulations would make more sense, and I think that certainly is true. However, it is incredibly tricky at times and

as I said earlier, in a lot of States it simply would not work. I don't recommend that as a model.

It is working in our State and one of the things that we are doing on the State side and a lot of States do that is we have State regulations. You also have those certification requirements for HCFA that really most hospitals and HMOs and home health agencies are most concerned about dealing with. But on the State side, our regulations for health facilities and for those kinds of things we have done at the State level, I think, do make more sense.

They are less restrictive. They can be changed quickly.

My State board of health, if I have done my homework with the providers and with the board members, I can change a regulation. As a matter of fact, with the EMS system just sort of to make a point, I went from a recommendation by our EMS State advisory council through approval by the Board of Health to go to a public hearing process, working with the industry and communities through final adoption of the regulation in a 60-day period, which, you know, with Federal laws and regulations in 60 days, you can't even get a letter to the right person that has to respond to it.

So I think if it is done right, you know, we can respond appropriately with less regulation, regulations that make sense. It is whether or not we can do it right, and, you know, I am not saying that that is an easy thing to do at all.

Mr. PAWLOWSKI. If you look at cost benefit, regulations are important, but if you look at the payment system, the amount of people we have working in the health system for the multiple insurance forms, the duplication, the needed systems to keep track of all these charges, that is a tremendous area where we can save manpower, money and time if we simplified the payment system mechanism. That is one area.

Number two is tort reform. Anybody in health care will tell you, doctors are terrified of malpractice. We are doing excessive tests, we are doing excessive documentation, primarily to cover people's backsides, and I think that has to be addressed cost-benefitwise.

There is a point where it costs way too much to protect against that catastrophic situation.

Mr. GRANDY. Our time has expired and we have to go vote, but one final point on that. That is an area where we probably could move without waiting for the comprehensive health care reform to be incorporated around tort reform.

Do you all agree that we should do that at least in the interim?

Mr. PAWLOWSKI. Absolutely.

Mr. WHITTEN. Absolutely.

Mr. MCGREW. No question.

Chairman STARK. I want to thank the panel. You have been candid and helpful and I hope we can look forward to working with you as we try to solve this tricky problem of how we can bring health care to everyone.

Thank you very much for your participation. The hearing is adjourned.

[Whereupon, at 2:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Written Testimony on Health Care Service Delivery Infrastructure
In Inner City and Rural Communities for the Subcommittee on Health,
Committee on Ways and Means
U.S. House of Representatives

Submitted by Doris L. Ralston, MPA, CHES, Staff Legislative Affairs Coordinator,
American Medical Student Association

Background

The American Medical Student Association (AMSA) is the nation's largest and oldest independent association representing physicians-in-training (premed - residency). Contrary to what one might think, AMSA's mission could be characterized as one of patient advocate. The American Medical Student Association supports the concept that health care is a right and not a privilege, and opposes the accrual of excessive profits by health care related industries and providers. In that the American Medical Student Association has adopted these principles of which neither are self-serving, it believes it has a responsibility to provide written testimony, addressing the health care service delivery infrastructure in inner city and rural communities and it is offered from a unique perspective.

Problems Facing Health Care Delivery Systems in Underserved Areas

In inner city and rural communities barriers to access are numerous and interrelated. Although lack of health insurance coverage is the major barrier to health care, it alone will not remedy the problems of access facing these areas. To address possible solutions to the access dilemma, the barriers and then their solutions need to be defined in terms of the communities themselves, providers, medical education and training and reimbursement or compensation. All of these are interrelated and impact access.

It is evident after reviewing the demographics of these communities, that characteristics of the population in themselves present as obstacles. Characteristics of inner city areas include a population that is dense, minority based, less educated than the general population; with no insurance, violence is prevalent and their economic status trails the general population. According to the 1993 Council on Graduate Medical Education (COGME), "50% of many minority households do not have telephones." People who are employed usually have to choose between going to work or going to the clinic. In summary, inner city populations are predominately minority, from diverse cultures, poor, unemployed and poorly educated.

Rural communities are sparsely populated over a large defined geographical area, and also tend to be less educated than the general population, self-employed with no insurance or unemployed and two parent families are most prevalent. Agricultural and small manufacturing tend to be the occupations of those living in rural America.

In both the inner city and rural communities, hours of clinic operation, distance to clinics, culture, language and communication systems as well as a paucity of providers or nonexistent providers present as barriers to health care access, particularly access to primary care.

The system of care in inner city and rural communities is really a non-system in that it forces these communities to utilize emergency rooms for care and encourages them to postpone needed routine care. Both of these impact the costs of services to everyone, and the health status of the communities, because the condition of the patients presenting are so bad that the costs are unnecessarily prohibitive and outcomes are not optimal.

Access to Health Care Solution

Despite a substantial increase in the total physician supply, maldistribution of providers exists in inner city and rural communities. There also is maldistribution among generalist physicians and subspecialists. In addition to the maldistribution issues, there is a shortage of minority and generalist physicians. Minority physicians and primary care doctors are more likely to serve inner city populations according to the COGME Third Report. Family practitioners and general surgeons are more likely to serve rural populations. Since less than 10% of obstetricians practice in rural areas, family practitioners historically provided these services, but these services have declined markedly with increases in malpractice claims. Thus it is reasonable to target recruitment efforts.

Research reveals that people recruited from underserved areas into health care careers tend to return to these communities as practitioners. Although physician supply needs to be curtailed, future recruitment efforts need to focus on underrepresented minorities. They are better able to reduce the language and cultural barriers that exist in these communities and serve a much needed community leadership role.

Barriers to the recruitment and retention of providers in these communities include: a paucity of providers, high utilization demands on current providers, lack of professional education opportunities and specialty support, insufficient exposure and training in inner city and rural community settings, reimbursement and compensation issues-particularly with Medicaid, lack of relief services, underequipped facilities, lack of trained support personnel, poor understanding of the providers non-professional needs, spousal and significant other dissatisfaction with rural and inner city life, lack of personal time and privacy, frustration with social and professional isolation (specific to rural areas), their debt level, and violence associated with inner cities.

According to the 1993 Physician Payment Review Commission report, reimbursement levels for Medicaid beneficiaries in many states are far below Medicare levels, leading many doctors either to limit the numbers they are caring for or not serving this population at all. Physician payment reform needs to be developed in concert with comprehensive reform of our system. Include in Medicaid payment policies, reimbursement for services rendered by non physician practitioners. Furthermore, attention to allied health care providers needs to be considered. Physician assistants, nurse practitioners, and certified nurse practitioners have a role in providing access to care. AMSA urges that qualified nurses be given more responsibility in the care of patients with commensurately higher compensation.

Incentives for providing training in these settings would include: the allocation of Medicare funds to rural and inner city clinics to expose practitioners to at least four weeks of primary care rotations, allocation of Graduate Medical Education (GME) funding based on state work force needs. A culturally sensitive curriculum is needed to focus on recruitment and retention of a more heterogeneous group of providers as well as to break down the barriers associated with caring for a diverse population.

Medicare reimbursement should be expanded to include General Residency Program and Community Health Facilities as a means to increase community-based medical education. AMSA believes that federal money for the development of primary care residency programs should be given priority to program in family practice, internal medicine, pediatrics and OB/GYN oriented primary care.

The proliferation of facilities needs to be restrained. Regional centers for a defined geographical and population basis dedicated to serve high tech needs based on referral are needed.

Issues That Need to Be Resolved for Inner-city and Rural Areas Under Health Care Reform Proposals That Rely on Providing Access Through Competing Health Plans

AMSA supports the concept of prepaid group practices as a model to increase both the quality and quantity of health care delivery to all people, and supports the development and funding of Health Maintenance Organizations (HMO's) that do not have to compete for business or profits thereby eliminating disincentives to share cost saving strategies and technology.

AMSA urges that reimbursement policies of private health insurance carriers and federal health care programs such as Medicare and Medicaid be revised to include provisions for prepayment on a capitalism basis, equivalent reimbursement for services rendered regardless of geographic locale of practitioners for parity among urban and rural providers, equivalent reimbursement for performance of identical services of all physicians.

Managed competition needs to be mindful that if primary care physicians are the gatekeepers their income could rise dramatically and stress the current health care system until more primary care doctors are trained. Eventually an imbalance in specialists and subspecialists could occur with disparity in salaries for these if there are not incentives to prevent this from happening.

**STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION
FOR THE WRITTEN HEARING RECORD OF
THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH**

On behalf of the American Osteopathic Association, thank you for the opportunity to present testimony for the written record of the June 24, 1993 inner city and rural health care hearing before the House Ways and Means Subcommittee on Health. The AOA is uniquely qualified to address these issues, because the osteopathic profession has demonstrated, for over one hundred years, an unsurpassed level of dedication and success in providing a disproportionate number of primary care physicians, many of whom deliver health care in underserved areas.

Specifically, while osteopathic physicians constitute only 5.5 percent of the nation's physician-manpower, they represent more than 15 percent of all physicians practicing in communities with populations of less than 10,000 people. The figure climbs past 18 percent in rural counties with populations of less than 2,500. In addition, osteopathic physicians serve 14 percent of the Medicare and 25 percent of the Medicaid populations. In all, each year over one hundred million patient visits are made to osteopathic physicians.

Further, the unique focus of osteopathic medicine, with its guiding principle of treating the whole person, has rooted the profession in a philosophy which emphasizes primary care and prevention, and has contributed to making the profession one of today's fastest growing segments of the medical professions.

The AOA believes that manpower shortage areas could be greatly assisted by increasing the number of primary care physicians trained in the United States and suggests changes to the current method of financing graduate medical education as the best way to realize this goal. Further, the profession wholeheartedly supports the use of loan forgiveness programs to attract physicians to underserved areas. In addition, home health care reimbursement and malpractice insurance issues must be resolved before the total problem can be addressed. Finally, the profession sincerely believes that physicians must continue providing free care to those in need. Comments on these suggestions follow.

GME FINANCING

When one considers the Office of Technology Assessment (OTA) statistics which indicate that rural health care provider shortages are staggering and seem insurmountable, it is worthy to note that many osteopathic physicians serve in settings where they are the only physician in the county. Further, while OTA's research indicates that in some rural counties there is no physician trained to provide obstetric care, the educational directive of the osteopathic profession ensures that every osteopathic physician has exposure to all areas of primary care. Indeed, a D.O. may choose to specialize, but the unique osteopathic internship requires a rotation in internal medicine, OB/GYN, family practice and surgery, ensuring that osteopathic physicians are *first* trained as primary care physicians. A large

number of clinical rotations experienced by osteopathic medical students take place in community hospitals, where the teaching role models to which they are exposed are in general practice.

The AOA agrees with the findings of the Physician Payment Review Commission and HHS's Council on Graduate Medical Education that the nation has too few generalist-physicians and far too many specialists. This situation has caused a significant and critical demand for primary care physicians, especially in rural areas. The osteopathic profession is quite proud of the fact that, since its beginning over 100 years ago, the profession has always graduated more than 50 percent of its physicians in primary care areas. Today, over 58 percent of osteopathic physicians practice in such areas.

In order to continue to train a majority of osteopathic primary care physicians, and to increase such commitment in the allopathic disciplines, however, current graduate medical education payment mechanisms must be changed. Currently, certain large and university-based hospitals are receiving graduate medical education funds based on the historical expenditures far in excess of the national average. Armed with a rich medical education budget, these institutions generally focus on establishing top-notch, highly specialized training programs.

As a result of this reality, the current reimbursement system has rewarded with financial incentives the larger more costly training programs which train more high-tech specialty and sub-specialty oriented residents. Meanwhile, smaller, less costly community hospitals, often osteopathic, train fewer residents and have access to less resources due to traditionally lower reimbursement levels. A major problem results from this scenario; specifically, larger institutions usually have programs that encourage specialty and sub-specialty training over primary care training, and, therefore, reduce the number of primary care physicians entering the work force.

Several options exist to more evenly allocate the funds to residency programs and to specifically encourage primary care training.

- 1) Reimbursement per intern and resident should be set at the national median, adjusted for regional differences with the wage index.

This change would allow smaller hospitals with primary care training programs that currently have rates below the national average to be more competitive for medical school graduates. These hospitals, which usually train a majority of the total primary care residents in the U.S. would be able to provide more paid educators and role models, and more competitive stipends for residents, which will direct more residents into facilities that have primary care emphasis.

- 2) Direct medical education costs should be fully reimbursed for the intern year, where required, plus the number of years it takes for initial certification. Reimbursement should be reduced or eliminated for training of subsequent specialty years.

The savings realized by this proposal could be allocated to hospitals that concentrate on primary care education.

If the 50/50 ratio of primary care physician to specialist was realized, many of the problems associated with insufficient providers, both in terms of number and training, would be rectified. The clinical training portion of a physician's training programs should require that all students participate in general practice clerkships in an office serving the health needs of both rural and urban underserved populations.

LOAN FORGIVENESS

Another method to attract physicians to underserved areas is to trade medical school debt reduction and cancellation for service to needy areas. For example, a program started by Roger Pelli, now an osteopathic physician practicing in rural Maine, offers a means for urban or rural health professional shortage areas to contribute to the education of physicians, certified nurse practitioners, certified nurse midwives, or physician assistants in return for their service to that community after their training is complete. Dr. Pelli was a physician's assistant who wished to become a physician, but lacked the financial means to do so. Through working with his community and Senator George Mitchell (D-ME), the Pelli Grant Program emerged. Beginning in 1991, the program was authorized to operate under a three-year demonstration authority. Now in its second year of operation, and with only \$500,000 in annual federal grant funding the program, National Health Service Corp officials estimate that by the end of 1993 103 grants will have been issued to aspiring health professionals. The federal portion of the grant covers 40 percent of the cost of educating the health professional, with the 60 percent balance funded through community or state funds.* To ensure optimum participation and success, programs such as this need additional funding and support.

While additional or new federal and state financial support may be necessary to implement these programs, such spending may be offset by the decrease in the number of patients who would otherwise seek primary care at their local hospital emergency room. Further, such support would reduce the number of costly, critical cases which develop in the absence of accessible front-line preventive and primary health care.

- * This program is in its final year of funding authority, but was included in President Clinton's FY '94 budget for an additional year of funding at the \$500,000 level.

HOME HEALTH CARE REIMBURSEMENT

An area of considerable difficulty for physicians practicing in rural America is home health services. For example, the office of one osteopathic physician practicing in a rural area is 22 miles from the hospital where he does daily rounds. He has several home-bound patients who live an average of 35 miles from him in all directions. While few of these patient are insured privately, most are covered by Medicare and Medicaid; however, Medicare does not reimburse physicians for intermittent acute care administered in the home and overseen by a physician.

The AOA believes that home health care services, which provide Medicare recipients with intermittent acute care, are a necessary, and often economically favorable alternative to in-patient hospitalization or nursing home treatment. However, the AOA has become increasingly concerned about the inability of physicians to gain reimbursement for the services that they provide under this program. While home health care is usually provided by visiting nurses, it must be understood that such care is executed under the instruction, management and signatory authority of the attending physician. In fact, the attending physician remains legally and ethically responsible for these patients as they are undergoing home health care. Appropriate reimbursement for such services would also serve as an incentive to practice in underserved areas.

MEDICAL MALPRACTICE

Manpower shortages also are caused, in part, by inadequate malpractice insurance or excessive coverage costs. Malpractice insurance costs, especially for obstetric services, often cause physicians to forfeit or reduce their practices and even forfeit their licenses. Others have been reluctant to provide services to indigent patients because costs of service does not offset the amount of the medical malpractice insurance needed to provide that service. Legislation alleviating the dis-incentive to provide care within one's practice, perhaps similar to the recently enacted Federally Supported Health Centers Assistance Act (P.L. 102-501), will greatly aid in eradicating this problem.

VOLUNTEERISM

Finally, while certainly no panacea, federal, state and local governments should work in cooperation with physicians to encourage and organize the donation of health care services to the medically underserved in their local communities or states. In keeping with the osteopathic philosophy, each year osteopathic physicians donate millions of dollars in medical care to the indigent and underserved. For example, in the wake of 1992's Hurricane Andrew, it is estimated that 75 percent of the physicians serving the storm's

victims were D.O.s. In addition, a recently completed survey of osteopathic volunteerism at the state-level revealed many innovative approaches to offering voluntary assistance to the medically-undeserved, while offering insight into the difficulties some areas experience in attempting to offer free help. The results of that survey are attached.

In conclusion, as evidenced by more than 100 years of commitment and dedication, the AOA is fully supportive of programs that will enhance the primary care physician population, and nurture growth in the number of physicians serving in health provider shortage areas. Current graduate medical education payment mechanisms must be changed, bringing the financial focus away from those institutions receiving graduate medical education funds based on the historical expenditures, and redirect some of that funding to programs dedicated to primary care and serving underserved populations. Further, programs having a clear and positive impact on increasing the number of primary care providers in rural and urban health professional shortage areas, such as the Pelli Grant program, should be expanded. Rural physicians, sometimes the only physician serving in a geographically vast area should be reimbursed for providing the coordination and oversight of care provided to their home-bound patients. Finally, when possible, volunteerism among medical professionals should be encouraged.

**RESULTS OF AMERICAN OSTEOPATHIC ASSOCIATION
ACCESS TO CARE STATE SURVEY
AS OF JULY, 1993**

STATE	ACTION	OBSTACLES
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS) -a state run program requiring each county to care for the un- and under-insured through sliding scale clinics.	The state's osteopathic community "could entertain" providing care to the under-served on a scheduled basis; however, some concern exists regarding servicing groups that make a cognitive choice to be uninsured vs. those who are indigent.
ARKANSAS	Individual D.O.s participate in the state's "Good Samaritan" program through which a free office visit is provided to those who can't afford to pay.	Most of Arkansas's D.O.s practice in rural and poor communities and participate in the state's Medicaid program, despite its low reimbursement level among the states.
COLORADO	The Colorado Society of Osteopathic Medicine conducted a state-wide survey of D.O.s requesting information on their volunteer activities. Of the respondents, 88 percent indicated that they would like to work with other D.O.s in Colorado to increase health care access for the medically underserved. The majority of respondents indicated that they provide pro-bono or reduced-rate office services at regularly scheduled times. Others indicated that they participate in the Medicaid program which covers about 25 percent of usual charges.	Several of those responding indicated that they would be more willing to provide pro-bono work if adequate screening to determine truly needy patients could be done. Many of Colorado's D.O.s feel that the cost of laboratory services creates a formidable obstacle to providing appropriate, free care to the indigent. The need for protection from liability for uncompensated care, and the frustration that patients need to take some responsibility for their health (i.e., healthier lifestyles, \$1.00 co-pay) were also mentioned.

STATE	ACTION	OBSTACLES
FLORIDA	<p>The Florida Osteopathic Medical Association provided a county-by-county report on D.O.s participation in local programs. The programs are mostly county and hospital-initiated, with D.O.s participating in reduced-cost HMOs for working mothers who could not otherwise afford coverage, volunteering on a weekly, rotating basis at AIDS clinics and the Health Department, offering free school physicals and screening through schools. One Florida hospital requires physicians with staff privileges to work a certain number of shifts per month in the Emergency Room treating local indigent patients. After ten years of service with the hospital, physicians are no longer required to serve, although many continue to do so. On a state-wide level, FOMA is participating in the "Physician Volunteerism Task Force," a group charged with identifying areas of need and providing health care throughout the state.</p> <p>(Several other programs were mentioned)</p>	N/A
GEORGIA	<p>In the absence of a coordinated, state-wide plan, D.O.s in Georgia are involved with volunteerism on an individual basis.</p>	<p>The small size of both the state's association and staff were cited as obstacles to greater coordination and encouragement of volunteerism among the state's osteopathic community.</p>

STATE	ACTION	OBSTACLES
INDIANA	The Indiana Association of Osteopathic Physicians and Surgeons has included articles in the state-wide publication the <u>Hoosier D.O.</u> , which call for osteopathic involvement in the "Share the Care" initiative. The Indiana Association has not issued surveys to the state's D.O.s, and was not able, therefore, to share specific cases of volunteerism.	N/A
IOWA	The Iowa Osteopathic Medical Association issued a survey to the state's D.O.s, requesting an estimate of the free care given to the un- and underinsured. With only about 15% of the state's osteopathic physicians responding, the total worth of the annual free care delivered by those physicians was between \$750,000 and \$1,000,000. Iowa's plastic surgeons, surgeons and other osteopathic specialists "routinely" provide free service to under-served groups. Particularly in rural areas, D.O.s provide free sports and school physicals, immunizations, well-baby care, and elderly care.	N/A
KANSAS	No state-wide efforts are in place, but many D.O.s in Kansas are providing care to the indigent individually.	Unique to the Kansas Association of Osteopathic Medicine was the suggestion that a national, organized, osteopathic initiative to serve the un- and under-insured should be done with national guidance and support (i.e., publicity, assistance, direction) from the AOA.
KENTUCKY	In the absence of a formal volunteer program, it was noted that 90% of Kentucky's D.O.s serve in rural areas and see only Medicaid patients. On a legislative note, the Governor established a "Task Force on Health Care Access and Affordability," and is expected to use their findings to work toward enacting health care reform legislation similar to Minnesota's.	The small size of Kentucky's osteopathic community was cited as the reason that state-wide, osteopathic initiatives are not pursued.

STATE	ACTION	OBSTACLES
MAINE	In the absence of a formal plan, Maine's D.O.s provide free care on an individual basis and participate in Medicaid.	The need for comprehensive, national health care reform.
MINNESOTA	The Minnesota Osteopathic Medical Society has been working to make sure that Minnesota's health care system, "HealthRight," is inclusive of D.O.s. One of the system's goals is to focus on preventive health care, giving priority to low-income families with children.	N/A
MISSOURI	<p>The Missouri Association of Osteopathic Physicians and Surgeons (MAOPS) cites several local initiatives to provide health care to the underserved regularly undertaken by D.O.s. These efforts include annual general health care screening in several communities, participation in providing free services through local, hospital-sponsored efforts, free health care to the indigent through clinics at osteopathic colleges as well as other such activities which assist in DO training, and a great number of individual D.O.s who volunteer on a weekly or monthly rotating basis at local clinics.</p> <p>MAOPS also intends to discuss the possibility of implementing a state-wide osteopathic volunteer effort at their October, 1992 Board of Trustees meeting.</p>	Medicaid reimbursements are 48th in the nation, leaving many D.O.s who see Medicaid patients to believe that they are already heavy participants in providing care voluntarily to the indigent.
NEW JERSEY	The School of Osteopathic Medicine at the University of Medicine and Dentistry of N.J. is involved with caring for the uninsured and underinsured in two cities, and has a migrant farm workers program.	

STATE	ACTION	OBSTACLES
OKLAHOMA	The Governor has appointed a state commission, which includes osteopathic representation, charged with developing findings and recommendations to be used toward the establishment of a state health care plan that is affordable and accessible universally.	State-wide, scheduled clinical hours have not been discussed; however, they suggest that, rather than looking solely to the osteopathic profession for help, the existing access problems must be addressed by "the broadest spectrum of health care interests."
TENNESSEE	In the absence of a coordinated, state-wide plan, D.O.s in Tennessee state are involved with volunteerism on an individual basis.	The small size of both the state association and staff were cited as obstacles to greater coordination and encouragement of volunteerism among the state's osteopathic community.
TEXAS	The Texas Osteopathic Medical Association (TOMA), in cooperation with Blue Cross/Blue Shield, is participating in the Caring for Children Foundation of Texas program which provides health care to children (ages 8-19) who fall through the cracks of public sector health programs. It is believed that approximately one million children in this age group are un- or under-insured, accounting for approximately 35% - 40% of the uninsured population in Texas.	N/A
VERMONT	Possible legislative answer - legislation still being negotiated that will impose universal health care in 3 - 4 years. It was reported that plans for D.O.s to provide clinic hours to the un- and under-insured at one hospital are in the discussion stage.	N/A

STATE	ACTION	OBSTACLES
WASHINGTON	Washington's state-wide initiative is included in the "Health Resources Plan," a Statutory Committee created as a legislative remedy to the access crisis through the medical education needs and goals of the state (D.O.s are represented at the policy making level). Among its tenets, the Committee will seek ways to increase the number of graduates intending to serve in shortage areas, develop a system which allocates scholarships and loan repayment requirements based on graduate's intention to serve in shortage areas, and determine the training needs of health professionals serving target populations.	Due to D.O. population over a very broad and rural geographic area, a state-wide, osteopathic plan has not been pursued.
WEST VIRGINIA	While no state-wide osteopathic programs are in place, D.O.s actively volunteer to assist the indigent on an individual basis. Several state and federal programs are in place which help West Virginia's un- and under insured with their health care needs. Some of those mentioned are the Physician Assured Access System, a state-run program with the single goal of promoting preventive health care for the indigent; the state's three medical schools provide care in rural training centers which are required to provide coverage to patients regardless of their ability to pay; federally funded rural primary care clinics required to take indigent patients.	The WVSOM recommends that access for the indigent would be greatly served by improving Medicaid reimbursements.
WISCONSIN	No formal, state-wide, osteopathic plan. Wide-spread pro bono work on an individual basis.	The need for comprehensive, national health care reform.

American Physical Therapy Association

The American Physical Therapy Association (APTA), the national association representing over 57,000 physical therapists, physical therapist assistants, and students of physical therapy submits the following testimony relative to the health care service delivery infrastructure in inner-city and rural communities.

As the Subcommittee is aware, the nation continues to face serious shortages of rehabilitation professionals, with the most dramatic need being physical therapists. Physical therapists help 900,000 individuals daily to restore health and alleviate pain. Working with people of all ages, physical therapists treat children in public schools who are disabled or need special attention, senior citizens in nursing homes suffering from arthritis or hip injury, patients in hospitals, athletes recovering from injury, employees of industrial plants injured at the work place, infants born of cocaine-addicted mothers, and veterans coping with an amputated leg or paralysis. Today's physical therapy profession serves a dynamic, comprehensive health care role in improving and maintaining the quality of life for millions of Americans.

Shortage of Physical Therapists

Many facilities and providers are increasingly unable to recruit sufficient numbers of physical therapists. The shortage of physical therapy personnel in the United States is widely documented.

- As of December, 1992, there were 131 accredited physical therapy programs (73 at the B.S. level; 58 at Master's level); and 126 PTA programs.
- According to the Bureau of Labor Statistics (BLS), there are an estimated 93,000 physical therapist jobs available in the U.S. today. Therefore, the demand for physical therapists exceeds the supply by 15,400. BLS data also indicates that the gap between supply and demand of physical therapists will continue to expand through the decade.
- There are an estimated 80,000 licensed physical therapists in the U.S. today. Of this population, 80% (64,000) work full time, 17% (13,600) work part time, 3% (2,400) are not working or are retired. Thus the current work force is estimated to be 77,600.
- The shortage is most deeply pronounced in this country's rural communities. Statistics compiled by the Institute of Medicine and published in 1989 show that in metropolitan areas there were 21.1 physical therapists per 100,000 residents, whereas in rural areas there were 12.7 per 100,000 residents.
- A 1988 survey by APTA's Private Practice Section of its members found only 27.3% of respondents practiced in rural areas.
- A 1990 study of physical therapists in Kansas found that 36 of 105 counties are without a physical therapist. The Kansas study also revealed that less than 10% of practicing physical therapists were located outside metropolitan areas.
- A 1990 Kentucky study reveals that, except for one county, the physical therapists per 100,000 people ratios fall below the 1988 state ratio (21) and the national ratio (36). The ratios in the western counties range from 0 to 63. When the study was completed, the current ratio was 28, and the national ratio was 40.

Chairman Stark, when announcing this hearing you correctly stated "Having a health insurance card is not enough to guarantee all Americans access to the health care services they need. Health care reform will not succeed if it ignores the need to improve the availability of services in our inner-city and rural communities." APTA applauds you and this Subcommittee in your efforts to address this problem.

Health care reform must focus on providing access for consumers to talented and skilled individuals in health care professions and increase support activities which would provide greater numbers of these skilled providers in those professions that have been experiencing shortages. Without an adequate number of clinicians, health care reform cannot begin to ensure the necessary scope, quality, and access to care. Financial support for education should be available on a basis broad enough to attract individuals from culturally diverse backgrounds. Support must be evenly extended beyond the traditional professions of medicine, dentistry and nursing.

Those professions, such as physical therapy, that are experiencing a shortage of faculty members and clinicians must receive funding to support innovative education models to facilitate individuals obtaining credentials in their field of study as well as to encourage non-traditional entry and creative access to education.

The next challenge in the continuum of education, recruitment and retention is to provide reasonable distribution of health professionals to adequately address patient access to services in rural and other underserved areas. Consideration should be given to expanding the current National Health Corps model to include those health care professions that have been experiencing shortages. This inability to produce enough therapists is caused by:

- inadequate number of educators in these professions;
- shortage of programs and inadequate class size nationwide; and
- decreasing funds for scholarships and loans to attract students into these programs.

The solution to the inadequate supply problem is to increase the number of physical therapists by expanding the number of faculty and the class size in existing programs. The success of this solution relies on appropriating increased funds for Title VII of the Public Health Service Act, which provides grants for rural health care training and development. At a time when the nationwide shortage of physical therapists has become severely acute in rural areas, the expansion of physical therapy educational programs is vital.

In addition to increasing the supply of physical therapists, Congress can remove several unnecessary barriers to care under the Medicare program which has an amplified impact on access to care in rural areas. The APTA is proposing four recommendations which we believe will increase access to physical therapy services while reducing the cost of care. The underlying tenet of our recommendations is that several provisions in existing Medicare law place unnecessary barriers in front of elderly patients, especially those in rural areas, seeking the services of physical therapists. Mandated physician involvement and limitations on physical therapists are costing the taxpayers and elderly patients unnecessary money and restricting their access to care.

Elimination of Office Requirement for Physical Therapists Who Only Perform Home Care

Section 1861(p) of the Health Insurance for the Aged Act should be amended to make it clear that physical therapists who furnish services only to patients in their homes need not maintain a fully-equipped office. Such a change will allow an expansion of physical therapists performing home care in underserved areas.

Section 1861(p) of the Health Insurance for the Aged Act (42 U.S.C. 1395x(p)), provides that outpatient physical therapy services furnished to beneficiaries will be covered by Medicare if the services are:

"Furnished by a physical therapist in independent practice, i.e., therapist renders services on own responsibility and free of the administrative and professional control of an employer; the individuals treated are his own patients and the therapist has the right to collect the fee or other compensation for the services rendered; the therapist maintains at own expense an office space and the necessary equipment to provide an adequate program of physical therapy; [and] is engaged in such practice on a regular basis. ..." 42 C.F.R. 405.232(e). Emphasis supplied.

HCFA has interpreted this statute so that physical therapists who furnish services on an outpatient basis exclusively in beneficiaries' homes must nonetheless maintain a fully-equipped office. While requirements that the physical therapist maintain a single repository for medical and financial records and that the therapist has access to necessary equipment are reasonable and appropriate. HCFA's rule is deterring physical therapists from furnishing services in patients' homes because they are required to incur costs for equipment and office space which they never use. Thus, Medicare beneficiaries who are home-bound or who reside in rural areas with no ready access to inpatient facilities are being denied physical therapy services which they need.

Medicare Direct Access Demonstration Project

Twenty-eight states allow health care consumers direct access to licensed physical therapists. This means they have eliminated costly and unnecessary physical involvement should the patient choose to directly visit a physical therapist. Medicare does not reimburse services unless the patient is "under the care of a physician," i.e. physician certification and recertification. The APTA urges Congress to take an initial step toward remedying this situation by authorizing the establishment of a demonstration project which would permit the delivery of physical therapy services to Medicare beneficiaries without

the requirement that the beneficiaries be "under the care of a physician."

APTA believes that direct access will save Medicare money because it would limit the unnecessary involvement of one health care practitioner in the delivery of services by another health care practitioner. Being under the care of a physician amounts to significant physician involvement in any particular beneficiary's episode of care. It includes initial physician referral, monthly physician/beneficiary visits, a physician review of the physical therapy plan of care every thirty days, and a physician recertification every thirty days of the beneficiary's continuing need for physical therapy services. Physician involvement should be on an as needed basis.

A University of Indianapolis study found 20% of physical therapy students planned to concentrate their job search in direct access states and 53% include direct access states in long term plans. Blue Cross and Blue Shield of Maryland reports no increase in utilization rates of physical therapy services as a result of direct access which was implemented in 1979.

Direct access for physical therapy is endorsed by the National Conference of State Legislators. Additionally, the legislatures of twenty-eight States have determined that patients are entitled to direct access to the services of licensed physical therapists. Medicare beneficiaries in these States, however, are not permitted to enjoy that right.

The objective of the project would be to compare the utilization rates and costs to the Medicare program of physical therapy services in the demonstration settings with those settings where physician involvement is mandated. This project would be implemented in a certain number of those twenty-eight States where State law permits direct access to physical therapy services, and it would apply to the delivery of outpatient physical therapy services. The demonstration project would be conducted over a period of time to be determined by Congress.

Until direct access is realized, Congress can streamline existing Medicare law to remove provisions which are inhibiting access to physical therapy services.

Repeal Medicare's \$750 Annual Limit on Physical Therapy Services

Section 1833 (g) of the Medicare statute provides that no more than \$750 in any calendar year may be considered as reimbursable incurred expenses for outpatient physical therapy services delivered by a physical therapist in independent practice. This arbitrary and unfair limit is not a cost containment measure but merely a disruption in Medicare beneficiaries' needed services and should therefore be repealed.

The \$750 limit does not always cover the cost of a Medicare beneficiary's physical therapy services. Physical therapy care for most illnesses and injuries requires a series of treatments rather than a single treatment, rendered pursuant to a plan of care over a period of several weeks or even months. While most physical therapy patients are able to receive a full course of treatment within the financial constraints of the \$750 limit, those who are not able to do so deserve the opportunity to remain under the care of their physical therapist of choice.

The \$750 limit is not a cost containment measure because it is not a limit on outpatient physical therapy services, but, rather, applies only to one setting in which these services are provided. When a Medicare beneficiary reaches the limit, he or she must seek out another provider of physical therapy services to continue Medicare reimbursable care. The alternative provider into whose care the beneficiary is then forced may be a physician, a hospital, or any other provider of outpatient physical therapy services so long as it is not another physical therapist in independent practice.

This situation can be particularly burdensome to Medicare beneficiaries who are homebound or who reside in rural areas where alternative providers may be scarce. It also can result in higher charges when the services are provided by physicians or institutionally-based providers.

Consequently, the limit of \$750 which is imposed on coverage of services rendered by a physical therapist in independent practice is neither cost-effective nor is it in the best interest of Medicare beneficiaries. Those patients most in need of treatment are faced with the choice of discontinuing treatment sooner than medically advisable, paying for continued treatment on their own, or receiving Medicare reimbursed physical therapy services in another, perhaps more costly, setting.

Extend Physician Recertification from 30 to 60 Days

A 1976 Health Care Financing Administration (HCFA) regulation (42 C.F.R. 405.1733), which implements Sec 1861(p) of the Health Insurance for the Aged Act (42 U.S.C. 1395x(p)), requires that the care rendered to a Medicare beneficiary, by a physical therapist in independent practice or a rehabilitation agency, must be recertified by a physician every thirty days. Extending the recertification period from thirty to sixty days would remove unnecessary time and expense on the patient, the therapist, and the Medicare system.

The short recertification period is an unnecessary encumbrance on therapists and their patients. The regulation requires that the physician must review a patient's plan of care and see the patient each month. This forces elderly patients with disabilities or injuries to endure the time, discomfort and expense (transportation costs to the physician's place of practice can be substantial, especially in rural areas) of a visit for paperwork and not medical reasons. Physical therapists must divert time from patient care to complete redundant paperwork for the physician's review.

A sixty day review is consistent with standard patient care in both the public and private sectors of medicine. It would place Medicare regulations in line with the traditional six to eight week review that physicians perform on non-Medicare patients. Presently, HCFA utilizes a sixty day review for outpatients who receive physical therapy from a comprehensive outpatient rehabilitation facility (CORF), or a home health agency. In 1982, HCFA proposed a thirty day recertification period for CORFs. After receiving comments on the proposal, HCFA decided on the sixty day period. An excerpt from the Federal Register notice justifying the change reads:

Comment: Review every 30 days is inappropriate because rehabilitation patients progress very gradually. Suggest every 60 or 90 days.

Response: We agree and have revised the regulations to require review every 60 days.
(47 Federal Register 56283, December 15, 1982)

Physical therapists would still be required to immediately notify the physician of any changes in the patient's condition and physicians would still retain the ability to review the care at closer intervals if necessary.

Section 1861(p) should be amended to ensure that physician evaluations are conducted in a manner which is least burdensome on the patient and health care providers.

The Congress has a large task ahead of it and our recommendations are small steps toward a more efficient health care system. Though small, they are steps in the right direction.

The APTA shares the desire of the American public, political leaders and other health care providers to make health services available to Americans in rural and other underserved areas. APTA appreciates your continued dedication to the well-being of the many Americans who require physical therapy services. Thank you for the opportunity to provide this testimony and to show our willingness to work with you to achieve our mutual objectives.

**STATEMENT OF SHEILA LYNE, RSM
COMMISSIONER, CHICAGO DEPARTMENT OF HEALTH**

**Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives**

**Hearing on Health Care Service Delivery Infrastructure in
Inner-City and Rural Communities**

June 24, 1993

Chairman Stark and other members of the Subcommittee on Health, House Ways and Means Committee: I am pleased that you have recognized that increasing access to health insurance, although a critical step, is not sufficient to guarantee universal access to appropriate health care services for inner-city urban communities. Although I, like the rest of my colleagues in public health, are excited by the prospect of health care reform, we know from our experiences that we need to do more than provide insurance coverage to our citizens if we are serious as a nation about improving the health status of our most hard-to-reach, disenfranchised population.

I am also pleased that the term "infrastructure" has been used in the title for this hearing, as it suggests that certain elements need to be in place as a foundation for successful health care delivery. As we are slowly beginning to become aware of the elements of the Administration's health care reform proposal, it appears that four components critical to making health care reform more responsive to the needs of our inner cities have not been sufficiently addressed, and they are to:

- A. Expand Primary Care Capacity
- B. Support Public Health Infrastructure
- C. Fund intensive preventive services targeted toward the needs of the inner-city poor
- D. Restore Public Decisionmaking

Before discussing these strategies in some detail and sharing with you some related experiences we in Chicago and Cook County have had, I will first give an overview of the health care needs of Chicago's inner-city communities and the problems which must be solved in all of the nation's urban centers.

Special Needs of Inner-City Communities

It is well-documented that low-income inner-city communities suffer disproportionately from poor health status. Limited or no access to care is a major reason for these poor outcomes, but we know there are other major contributors as well, such as poverty, cultural and language barriers.

Poor Health Status

- Chicago continues to have a stubbornly high infant mortality rate, which has resisted concerted efforts to significantly reduce it. In 1991 the rate was 15.2, and although the lowest in Chicago's history, it is still substantially higher than the nation's and the rate is more than twice as high for Blacks as it is for whites.
- Syphilis cases are increasing dramatically in Chicago as they have in many large cities.

- Poverty, homelessness and the AIDS epidemic have contributed to an upsurge in Tuberculosis.
- The number of AIDS cases reported each year has increased steadily since the first case was reported in 1980. This year we intent to record 1,500 additional cases and 1,000 deaths.
- Immunization rates among pre-school populations have dropped to dangerously low levels creating a reservoir for the spread of measles. As we continue to struggle to reach underserved populations, we have learned that increasing financial access alone will not necessarily improve immunization status, a finding reflected in the Clinton Administration's Immunization proposal.
- Lead poisoning affects an estimated 10,000 Chicago children each year; only 20 percent of cases are detected.
- Homicide is now the leading cause of death among African-American males aged 15-34.

Access Problems

The Chicago and Cook County Health Care Summit was convened by Mayor Richard M. Daley of Chicago and the President of the Cook County Board in 1990 to address longstanding problems faced by residents of Cook County in accessing quality and affordable health care services.

The Summit estimated that there are 400,000 medically indigent Chicagoans and 600,000 Medicaid recipients, totalling 1 million medically needy and Medicaid persons, one-third of the City's population. Other findings of the Summit:

- There is a shortage of one-million primary care visits in Chicago alone.
- 14 hospitals had closed in the 1980's, primarily in medically underserved areas, further reducing access to care to low-income populations.
- There is a reluctance among private providers to provide inpatient and outpatient care to low-income people, even those covered by Medicaid.
- Demand exceeds capacity for nearly all services and clinics accessible to low-income people.
- Publicly-funded clinics are overcrowded, resulting in long waiting times.
- There is a great deal of fragmentation within the health care system and the lack of coordination among providers of care, especially public providers.
- Populations that experience illness, poverty and special needs are at high risk of "falling through the cracks" of even a well-functioning, well-financed health care system.
- Hospital emergency rooms are inappropriately used for primary care as a last resort, resulting in long waiting times and fragmented care.
- Nearly one-half of Chicago's communities have been designated by DHHS as Health Professional Shortage Areas.

Eroding federal support of traditional public health problems

Federal support for traditional public health problems such as sexually transmitted diseases, tuberculosis, and vaccine-preventable childhood diseases has been steadily eroding, which has greatly strained the ability of local governments like Chicago to deal with public health problems. Yet traditional public health problems will continue to persist, and, in the case of tuberculosis, have returned in a more virulent form. Despite the 1990 measles epidemic and the current surges in tuberculosis and sexually transmitted diseases, federal funding for public health programs remains woefully inadequate.

Proposed strategies

A. EXPAND PRIMARY CARE CAPACITY

The shortage of quality, accessible, and acceptable primary care documented locally through Chicago and Cook County is also experienced nationally in all of our urban underserved areas, and would not be eliminated solely through a national health program which assured financial access. Primary care services have been long neglected and additional investment will be needed to increase capacity. We propose this investment to occur through the following methods:

Establish additional community health centers as a proven effective model for providing services in medically underserved, low-income areas. As other speakers have testified, federally-funded health centers, including those funded under sections 329, 330 and 340 of the Public Health Service Act, and local health departments, have a long track record of providing community-based, quality services to hard-to-reach populations.

Increase the supply of physicians trained in primary care in underserved communities.

- Redirect federal funding of medical education to favor primary care.
- Offer special loan repayment programs and scholarships for medical students who choose primary care specialties.
- Support full appropriation of the National Health Service Corps, which provides loans and scholarships to students who in return promise to serve in Health Professional Shortage Areas.
- As leaders of the medical community have proposed, consider mandatory service in primary care for all medical graduates in underserved communities.

Include providers who are already serving hard-to-reach populations in managed care arrangements arising out of health care reform, even if that means deviation from the proposed managed competition model in certain areas. As one testifier at these hearings recommended, a "managed cooperation" model should be used for hard-to-reach populations, such as residents of our inner cities. We in Chicago have the beginnings of a "managed cooperation" network that could work quite well within an overall managed care framework.

The Chicago Ambulatory Care Council was convened in 1991 by the City and County as a successor to the Health Care Summit to devise ways to expand and coordinate a system of ambulatory care services to low-income persons in Cook County. The Council serves as a forum to develop local health policy, formulate plans, coordinate implementation, and advocate for state and national legislation to support these efforts. The Council has established networks of public and private providers of primary, secondary, and tertiary care at the district level who are organizing themselves to maximize efficiency, reduce duplication, and make available the most comprehensive array of services to low-income community residents. These provider networks could very easily be adapted to an overall health reform managed competition plan, and would enable local leaders to directly remedy

potential problems with implementing a "pure" managed competition model in large urban areas.

B. PUBLIC HEALTH INFRASTRUCTURE

Even if a managed competition health reform model eventually covered all Americans, the public health infrastructure would need to be strengthened, as traditional public health services would not be covered through managed care. It took the 1990 measles epidemic and the current surges in tuberculosis and sexually transmitted diseases to increase the federal funding stream for public health programs. To prevent further epidemics of preventable and controllable communicable diseases and restore the public health infrastructure we must:

- Increase funding of traditional public health services, including tuberculosis, STD, immunization, and lead poisoning programs.
- Support funding of patient tracking systems needed by tuberculosis, STD and immunization programs.
- Continue to increase the amounts of AIDS funding available for prevention and service delivery at the local level, but not at the expense of other communicable diseases.

C. FUND INTENSIVE PREVENTIVE SERVICES TARGETED TOWARD THE NEEDS OF THE INNER-CITY POOR

Although the Administration has suggested that the basic benefits package will contain more than strict medical care, I believe that those of us in public health must continue to emphasize that a wide array of preventive health services must be part of the overall funded plan, not just those services that may be provided in a physician's office through a managed competition insurance coverage plan.

For inner-city populations, it is not sufficient to use as a model the "prevention" services that have been traditionally provided by HMOs and in other managed care settings. The "preventive medicine" practiced is designed to decrease medical care utilization and decrease costs. The efforts have been geared toward a largely white, middle-class, healthy population, who, with minor lifestyle changes, such as reducing their sodium or fat intake, could enhance their health but would most likely not significantly increase their life expectancy.

In contrast, the types of prevention services needed by low-income inner-city communities are much different, since, in many cases, the health issues facing this population are indeed a matter of life and death. Infant mortality; violence; disproportionately high rates of diabetes, hypertension, and cancer require much more intensive interventions than the problems exhibited by an insured, middle-class population.

- View violence as a public health issue. Garner resources for violence prevention. Seek federal legislation limiting and controlling handguns and eliminating assault weapons in all areas of the country.
- Increase funding for substance abuse prevention and treatment.
- Increase WIC funding so that all eligible mothers and children can be served, thus enhancing birth outcomes.
- Provide funds for infant mortality reduction programs in high-risk urban areas to support strategies known to be effective.

- Provide support for research and program implementation aimed at decreasing smoking among minority, low-income populations.
- Provide funding for case management so that low-income multi-problem families can receive coordinated care and services.
- Increase funding for public health nursing who can work as a liaison between families being followed by local health departments and the medical provider.

D. RESTORE LOCAL DECISION MAKING

Even within a system for assuring some type of health insurance for all Americans, a process will be needed for local communities to set priorities and assure that health care dollars are allocated in a way that makes the most sense in a particular area.

Chicago has developed several planning councils that can serve as models for a federally sponsored planning program. The Chicago/Cook County Ambulatory Care Council and the Ryan White Services Planning Council each has allowed local providers, consumers, government to make decisions about the structure and functioning of the local health care system.

Part of the Ambulatory Care Council strategy in Chicago and Cook County has been the formation of District Health Councils, composed of providers, consumers and government representatives. These District Health Councils are the focal point for building responsible community-based ambulatory care systems within the county. District Health Councils have been charged with developing and implementing action plans for organizing health resources in their areas based on a community needs analysis.

These planning mechanisms have been effective in balancing the interests of large institutions with the needs of the community and have great potential as a component of health care reform to assure that at the local level needed health care services are available.



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Submitted by Representative Long on behalf of the Congressional Rural Caucus for inclusion in the record for:

Ways & Means Subcommittee on Health
Hearing on Inner City and Rural Health Care Delivery
Thursday, June 24, 1993

I am pleased to submit for the record the views of the Congressional Rural Caucus on the importance of addressing the needs of rural residents with regard to health care. Health care has been identified as a top priority for our organization and we commend the Subcommittee for its attention to this important issue. The Congressional Rural Caucus has endorsed the Rural Health Care Coalition Priorities for Health System Reform and will continue to work to ensure that the unique problems facing rural health care are addressed in any reform considered by the Congress.

The problems of rural health care have been clearly documented -- financial viability of hospitals; training, recruitment and retention of providers; quality of care; adequacy of emergency medical services; and barriers to care, even when services are available, including poverty, lack of insurance and transportation. These problems have resulted in rural residents recording a higher incidence of chronic conditions, a higher infant mortality rate, and selected health status indicators -- among blacks, migrant workers, and those living in rural Appalachia and on Indian reservations -- that more closely resemble those found in many developing countries.

Unfortunately, while the problems are evident, the solutions are not as definitive. Identifying solutions is further complicated by the fact that not only do rural areas have different needs from urban areas, but different rural areas have very different needs. Any proposal for reform must take into account that a rural area of Virginia has very different needs than a rural area of Montana.

The potential to reform our nation's health care system offers us the unique opportunity to look at the weaknesses of our current system and propose effective means to reform these areas. Whatever structure health care reform may take, the members of the Congressional Rural Caucus strongly believe there must be provisions to address the needs of rural residents. These provisions should include development of integrated delivery systems, encouragement of state and local participation, alleviation of provider shortages, improving access to emergency services and assuring quality care.

Again, we appreciate the Subcommittee's attention to this issue and look forward to working with Members of the Subcommittee as legislation to reform our nation's health care system is considered by the House.

STATEMENT OF PAUL B. MCGINNIS, PROJECT DIRECTOR,
MOUNTAIN STATES GROUP, NATIONAL RURAL HEALTH ASSOCIATION

Chairman Stark, members of the House Ways and Means Subcommittee on Health, this testimony is presented on behalf of the National Rural Health Association, a private non-profit association dedicated to improving health services in rural America. I am Paul McGinnis, a former Board Director of the National Rural Health Association. I am currently Project Director for the Mountain States Group, a private non-profit human resource organization located in Boise, Idaho and Salem, Oregon.

I developed and direct a project called **Community Decision Making**. It is supported by private foundation dollars from the M.J. Murdock Charitable Trust and the Northwest Area Foundation. The premise **Community Decision Making** is simple. Rural residents should have an opportunity to decide what level of health services should be available in their communities and how that system should be financed. The project has been implemented in communities in Oregon, Washington, Montana, Idaho, Alaska, New Mexico, Alabama, and Georgia.

The National Rural Health Association believes strongly in community empowerment and in promoting innovative solutions to problems at the local level. I work at the local level and have a perspective of how the programs the federal government administers are utilized.

Many rural community health systems are unprepared for change. Trustees of rural hospitals are operating with little knowledge of the whole health care system. In fact, they have limited knowledge of their own system. Unpublished data from a survey of rural hospital trustees, currently being tabulated by the University of Washington School of Medicine, indicates that only 52% of respondents knew how many beds their hospital had, less than 30% could correctly say how much revenue they had last year, how many admissions they had, how many employees the hospital had, or how many babies were delivered. These are fundamental pieces of information that people entrusted to oversee several million dollar businesses should know. They are the essential elements from which plans are derived. In my personal dealings with Federal Community and Migrant Health Centers boards, I believe they too have a limited understanding of their environment.

These are well-meaning and honest community members trying to run a very complex system without the benefit of training and education. These trustees represent the community, but in most cases they are not "representative of" the community. Community and Migrant Health Centers are the exception to this because of federal mandates on board composition. However, that does not mean they are better prepared for decision making.

The problems and solutions to rural health care and, with implications for health reform, are at the community level. Because most of the rural health care delivery system in rural areas is public or private non-profit, the citizens of those communities need to be directly involved in health care decision-making. The citizen involvement must go far beyond the board room. Community based decision making, however, is more complex than decision making conducted by institutions or health care providers alone, and communities are frequently not prepared to organize and facilitate broad-based decision making.

If the rural health system is failing, local health care leaders tend to blame outsiders for their demise. However, the solution is to fix problems, not fix blame. A recent study vividly illustrates the level of blame and provides a framework for reviewing federal initiatives. The mayors of 130 communities where the rural hospital had closed were surveyed for a study titled *"Causes and Consequences of Rural Small Hospital Closures from the Perspectives of Mayors,"* by Hart, Pirani, and Rosenblatt at the University of Washington Rural Health Research Center.

Mayors believed that the number one reason their hospital failed was government reimbursement policies. Federal efforts to eliminate the differential in payment for Medicare between urban and rural providers should be accelerated. Any increases in payment to rural physicians and hospitals that gets them closer to covering at least the cost of delivering care is imperative. However, laying the blame for the closure on this reason is inappropriate. First, as public or non-profit institutions, these hospitals don't pay taxes because they are supposed to be meeting an essential community need. These hospitals are obligated to serve people regardless of their ability to pay. Aside from that, these are community members, friends, neighbors, and family.

The second most cited reason for the failure according to mayors was general financial problems. Put in another way, the community doesn't have enough money to support the system. In a study titled *"Are Dollars Really the Issue for the Survival of Rural Health Services?"*, Amundson and Hughes compared expenditures for all health services by community residents to the budgets of all the local private and public health resources. In all three cases, the amount of money spent on health care far exceeded the amount required to support that system. In one of the **Community Decision Making** communities, not included in the above study, it was determined that residents spent about \$11 million on inpatient care alone. Yet, the hospital, with a roughly \$3 million dollar budget, requires a tax subsidy just to remain open. The key is recapturing those expenditures by getting community residents to use the services they have locally.

Using a standardized survey in over fifty rural communities, 90% of residents responded that the existence of the hospital was "very important." However, the average market share for those hospitals was 35%. A rural primary care hospital can typically capture about 60% of the market share with the rest be appropriately referred to the next higher level of service. In fact, only 55% of the respondents said they would use their local hospital for a BROKEN ARM! An increase of local utilization by a mere ten percent would make an incredible difference on the operating bottom line.

Community members must be involved in defining the local health care system if they are going to be expected to use it under managed competition in health reform.

The third most cited reason for the hospital closure according to the mayors was the physician shortage. This is a misnomer, while there exists a maldistribution of physicians, there is not a shortage. Communities that have employed the **Community Decision Making** model have successfully recruited new doctors. They create a viable "business opportunity" for the provider and guarantee to finance the risk. Some communities will always require a subsidy for providers, that is why it is so important that the Migrant and Community Health Center funding be continued, that the National Health Service Corps⁷ expansion be accelerated, and that Area Health Education Centers be supported. Interdisciplinary Training Programs also help in alleviating these maldistributions by better preparing providers for the challenges of rural medicine.

The challenges that face rural health leadership are great. The communities need a menu of options and resources to select from. The federal government provides some highly successful options that should be expanded and continued. The Rural Hospital Transition Grant Program has been effectively utilized to improve services to the elderly. The Essential Access Community Hospital and Primary Care Hospital Program allows smaller communities the option of downsizing their services, while still retaining primary care components locally. This designation should be available to all communities. The federal Outreach Grant Program has helped forge partnerships in rural areas between providers. It should be retained and expanded.

At the community level, I am at the end of the line. There, one has an opportunity to see the effects of federal, state and private initiatives.

Let me tell you about a few of the communities that have solved issues themselves.

When the fifth physician in three years left the isolated high desert community of Burns in Harney County, Oregon, the health system hit rock bottom. In 1988 the sole remaining doctor was semi-retired and the approximately 7,800 residents faced the likely prospects of no doctor services or hospital.

The hospital was losing \$50,000 a month and had soaked all of the money out of the county's reserved fund. The head of the county commission was trying to run the hospital as well county government to save money. Harney County is over 10,000 square miles, about 1,000 square miles larger than New Hampshire. The next services were 130 miles away in either direction.

To finance these services the community made property tax assessments three times, twice to maintain services while in the planning stages and once to fund the district to implement services.

The first step of our Community Decision Making program is to hire a "Community Encourager" a local person to act as a liaison between the health care power holder and the local citizens. In Harney County, Ramona Bishop, a sheep rancher accepted the job. We train community encouragers in community development skills, group processes, health care issues and rural sociology and economics.

After the training, Ramona went back to Harney County and organized a Community Council composed of teachers, ranchers, forest service employees, retail merchants, farmers, bankers etc.

As part of the process, these council members agreed to represent their particular sector of the community and to form a focus group composed of peers. These people in turn talked to family and friends to develop a consensus list of health care issues residents are concerned with.

These council members are taught how to conduct needs assessments and learn skills for public policy citizen involvement. Once issues are identified the council conducts research and generates alternatives for the community to select from.

The county now boasts; four physicians, including a surgeon; a district hospital that enables the citizens to have a more direct voice in hospital operations and planning; a revitalized hospital foundation; trained advanced Emergency Medical Technicians and first responders; a professional hospital administrator; renovated hospital common areas and patient rooms; new services; and greater utilization of hospital services.

Harney County isn't an isolated case. Dillon, Montana created a community-wellness program, and added orthopaedic surgical services. Clearwater County, Idaho created an emergency medical service district and added two new physicians. The Ronde Indians in Oregon used the model to design the scope of services for their new health clinic. Their application is currently under review at Indian Health Services. And two months ago the people in Reidsville, GA began working on ways to improve services to the Migrant Farmworkers in their area.

Metline Falls, Washington, in a isolated rural community near Canada with a population of 2,000, whose hospital closed five years ago.

Many of the CDM communities have accessed federal Rural Health Transition Grant dollars, improved educational training through use of interactive video at Area Health Education Centers created partnerships to coordinate services for seniors and the mentally ill. They also utilized local Cooperative Extension services for skill building. All this because regular community members became informed about issues and were given the opportunity to do something about it. The Metline Falls community used the **Community Decision Making** process and a \$700,000 Rural Health Outreach grant to coordinate public health and primary care services through a three county region. After 1 1/2 years, the community recruited a primary care physician to work with a physician assistant.

The keys to success are simple. One, keep community energy focused on things they see and touch. Citizens will only become involved when they can see the results of their efforts in their back-yard. Two, trust citizens to make the right decisions. Educated and informed residents will make choices in the best interest of the community. Three, provide technical assistance that is relevant to lay people. Use a language people understand. Four, learn what federal and state and private resources are available, and choose those that are appropriate for your community.

The issues rural communities need to face in terms of health reform are clear.

Leadership A problem of leadership in rural communities, in terms of quality, numbers and turnover, is at the very core of the rural health dilemma. Research has shown a clear correlation between the quality and depth of leadership and community effectiveness to sustain health services. There has been little organized attention to the pernicious pattern of ineffectual leadership in many smaller rural communities. Rural leadership can be enhanced and nurtured. This can be achieved through current programs. The Bureau of Primary Care should add community-based planning dollars to Migrant and Community Health Center budgets with dollars for trustee development. Area Health Education Centers have technology in place to develop the capacity of both rural hospital providers and trustees. The hardware is in place. Funding for program development to be deployed on the "information highway" is what is needed. The United States Department of Agriculture, in conjunction with the Federal Office of Rural Health Policy has a program called the "National Health Initiative - Decisions for Health." This program needs full funding as it intends to cross the lines between provider and consumer to educate residents, using cooperative extension, on health reform issues; is working closely with the Center for Disease Control to enhance childhood immunizations; and lastly to effectively utilize communication technology.

Performance Rural communities are generally serviced by generalists, both clinical and administrative. The complex and technical nature of health care, therefore, puts extreme demands on rural providers. Tendencies to offer non-competitive salaries together with communities often being "training grounds" for staff and professionals have led to serious performance issues. This coupled with the tendency of many communities to avoid addressing performance failures, contributes to the threat of system demise. The federal Office of Rural Health Policy needs a technical assistance center. The technical assistance should be designed to enhance skills at the local level to improve continuity and performance.

Outmigration for Services Rural people in massive numbers leave their communities for health care services, even those available locally. They leave because of perceptions of poor quality and reputation, or they are referred out by providers. The only way to ensure satisfaction levels with the scope of service available is to directly involve the community in the decision-making process.

Complexity in Decision Making Fundamental decisions regarding the scope and future of health services demand broad community participation. This is especially true when communities are expected to subsidize local health services with tax dollars. There are few resources for communities to turn to for help. Community Decision Making programs like ours need to be deployed to rural areas. It is the absolute first step in recovery.

Relation to Community Economic Health It is widely recognized that health services such as hospitals or long-term care facilities are often among the largest employers in rural communities. There is an intimate relationship between the vitality of the health care system and the economic strength of the community. Health care services attract and retain people and industries for rural America. But, how much should a community subsidize services. At what level does the health system become a jobs bill program instead of an investment in community infrastructure. Cooperative Extension Economists could be provided with proven models to help communities determine how much they can invest in the health care system and still show a return.

The Community Decision Making process we employ is effective in improving a rural health delivery system. The basic assumptions employed in **Community Decision Making** have value and can be integrated into federal health reform initiatives. The assumptions are simple, yet powerful.

People have a right to participate in public affairs. Selecting representatives to serve on clinic and hospital boards is not enough. People need to participate directly to feel they can influence decision making. Organized coalitions of special interest groups should not dominate the rights of individual's needs and desires.

Health providers, not individuals, should initiate citizen involvement. Most rural health services are publicly owned or private non-profit organizations. In either case, citizens' opinions on decisions must be heard. Health providers need to reach out to people where they are to get them involved. Citizen involvement doesn't have to be contained to evening meetings. It can occur in peoples homes and workplaces. The health providers need to go to the people, not the other way around.

Appropriate strategies should be used to reduce the risk of citizen involvement. For health professionals and community members to reach a consensus on issues, they must establish a direct relationship, the closer the better. Strategies to involve citizens will vary depending on the goal sought. For example, giving information to the public may require different materials and approaches than getting information from the public. The value of residents time should always be respected; participation should be requested only when needed.

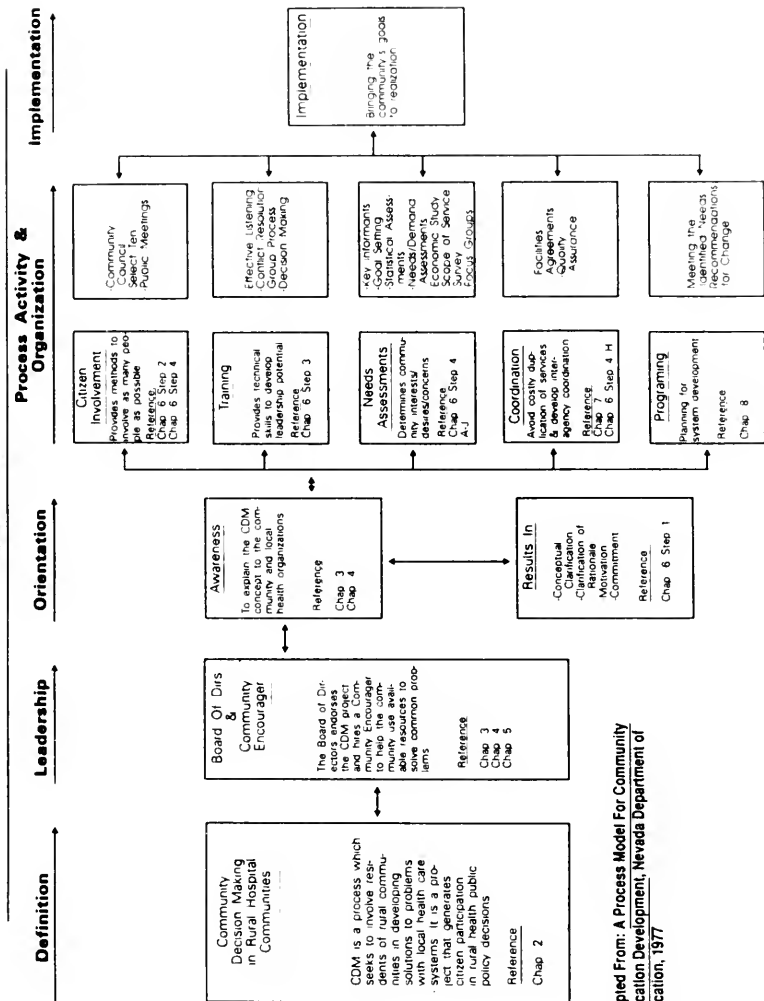
Planning is a learning experience. Citizens must first understand the basics of the health care delivery. They can then more easily analyze the health data the community needs to examine to make decisions. We must use a language people understand. The jargon associated with health care is intimidating. Issues need to be explained in terms that consumers use.

Adults learn best by doing. Adults will learn about the health system if they are actively involved in seeking solutions to problems. By conducting health assessments, rather than hiring consultants to do them, rural residents can better understand the origins of the current health care crises, the availability of options, and the costs and benefits of pursuing those options.

Communities should focus on local issues. Community participants should focus their efforts to improve the health care system at the local level. Concentrating on outsiders and forces beyond residents' control, such as insurance companies, federal Medicare policies, malpractice costs and licensure regulations, is less productive. Community residents need to provide the federal government with input, and then trust you to make options available to them.

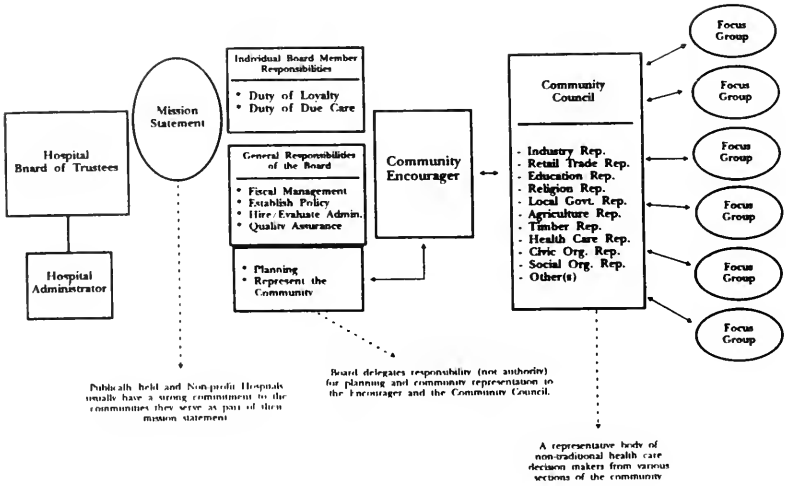
Informed people will make good decisions. By evaluating each option for change, addressing such issues as impact on the current health care system, political acceptability, and potential revenue sources, community members will avoid "shooting themselves in the foot." If properly informed, residents will make choices in the best interest of the community.

Attached are two models which detail the **Community Decision Making** process. You will note that the vehicle for citizen involvement is an indigenous worker known as a "Community Encourager." The Community Encourager acts as liaison between the health care system and the public. They take the community through the process of training and involving community members with skills and rural health education, conducting needs assessments, coordinating re sources and determining a programmed plan for action. The recommendations of the community are then forwarded to the proper authorities for implementation.



Adapted From: A Process Model For Community Education Development, Nevada Department of Education, 1977

CDM Relationships & Responsibilities



Statement of Louis Núñez, President,
National Puerto Rican Coalition, Inc.

House Ways and Means Committee
Subcommittee on Health
Hearings on Health Care Service Delivery Infrastructure
in Inner-City and Rural Communities

June 24, 1993

I am submitting this written statement as President of the National Puerto Rican Coalition (NPRC). NPRC is a membership association which represents over one hundred Puerto Rican community-based organizations as well as hundreds of concerned individuals. NPRC's goal is to further the social, economic, and political well-being of nearly six million American citizens of Puerto Rican descent throughout the United States and Puerto Rico. I wish to thank you for this opportunity to provide you with the National Puerto Rican Coalition's view of the problems regarding health care delivery and access to needed services for the Puerto Rican community in the United States, especially in inner-city areas.

INTRODUCTION

The provision of health care services to all Americans is a challenge to public policy. Most Americans have physician and hospital services available with some regularity. However, those Americans in lower socioeconomic groups, or with language barriers face severe disadvantages to adequate medical care. Puerto Ricans are probably the single most disenfranchised group in the United States vis-a-vis health and human services. For the 2.7 million Puerto Ricans in the States, 95% of whom live in urban areas, access to health care remains an enormous and overwhelming problem.

Between 1983 and 1986, 25% of Puerto Rican persons under the age of 65 relied solely on Medicaid for their health care coverage, compared to 18% of African-American persons and 3% of non-Hispanic Whites. Twenty-one percent of Puerto Ricans were uninsured, compared to 12% of non-Hispanic Whites. Only 62% of Puerto Rican mothers received prenatal care in the first trimester of pregnancy, compared to 82.7% of non-Hispanic Whites. As a result, Puerto Ricans had the highest infant mortality rate in the United States, 12.3%, between 1983 and 1985. Puerto Rican mothers also are almost twice as likely to give birth to underweight babies as non-Hispanic Whites. Finally, the number of AIDS cases continues to grow unabated in the Puerto Rican community, not only for substance abusers, but for women and children as well. These statistics illustrate that although Puerto Ricans depend on Medicaid more than any other ethnic group, their access to health care and consequently the condition of their overall health has not improved.

Aside from being under- or uninsured, which is a problem in itself, there are other intrinsic barriers which keep many Puerto Rican families from getting the best possible care. Such barriers result from unfriendly and often demeaning service providers, inaccessible clinics with overworked staff, a critical shortage of private primary health care providers, a crumbling public health system, bureaucratic hassles, and a lack of bilingual and culturally knowledgeable medical staff to treat Puerto Ricans.

Moreover, population projections for Puerto Ricans suggest that under the current health care delivery model the number of unserved or underserved Puerto Ricans may soon reach alarming proportions. In other words, with a 35% increase in the U.S. Puerto Rican population during the last decade, the need for affordable and adequate health care is essential for the future of the Puerto Rican community. Any reform in health care must be focused on and sensitive to the traditionally underserved populations such as the Puerto Rican community.

ACCESS TO HEALTH CARE SERVICES AND MEDICAL CARE

The single greatest health care challenge facing the Puerto Rican community in the mainland is "reasonable" access to health care services. Despite a number of past and current programs by federal and state government as well as industry, there is a growing cohort of Puerto Ricans who lack any access to many basic health care and human services. This is manifested, in part, by "excess" morbidity and mortality for many diseases, and the sad fact that often times the hospital emergency ward is the routine environment in which Puerto Ricans experience the United States' health care delivery system.

The recent outbreak of measles epidemics, a preventable disease, with deaths from this disease in Puerto Rican communities, represents a very serious problem. We have a startling juxtaposition of high tech expensive medical services for many in America, while even "basic" preventive immunizations are foregone for others. While this phenomenon is not new, it is worsening.

Physician Services & Health Manpower

A growing number of Puerto Ricans have limited availability for physician services. Despite an increase in aggregate physician supply in the United States to 650,000 in 1990, the number of physicians working in underserved Puerto Rican areas in the mainland remains remarkably low. Throughout the last two decades a number of programs have targeted strategies at improving physician services for Puerto Ricans; unfortunately, these programs have had only limited success for a variety of reasons. A new direction in health care policy is essential in addressing health manpower needs for Puerto Ricans.

Certain traditional health manpower programs of the past could perhaps be revisited: for example, student loan programs and give-back arrangements for physicians working in underserved Puerto Rican areas. One of the most promising of these new strategies for the United States would be to develop a large "nurse practitioner corp." This strategy would utilize an existing cohort of culturally sensitive nurses, perhaps 50,000 of the 1.6 million nurses, who would be retrained and directed as "nurse practitioners" into underserved Puerto Rican locales. This strategy would require the implementation of programs to train, empower, supervise, and finance this labor pool.

Hospital Care & Ambulatory Services

Aggregate spending on hospital inpatient care has increased dramatically during the last two decades. Puerto Ricans, however, have not enjoyed a full return on these expenditures. The majority of acute hospital inpatient care for Puerto Ricans are for emergency generated admissions to the hospital. Hospitals have been only marginally successful at redirecting some of the large inpatient funding stream into programs designed at ambulatory and/or community based health care delivery.

Most worrisome for Puerto Ricans is the continued decline in the availability of "user friendly" ambulatory health care services which incorporate culturally sensitive and, at times, bilingual programs for Puerto Ricans. Also problematic is the lack of outpatient care which, along with other social and economic factors, leads to a greater severity of illness with regards to inpatient admissions for Puerto Ricans.

Rapid expansion of ambulatory health services is needed. There are a number of strategies which may accomplish this goal. Using managed care models, redirecting and retraining groups of physician extenders and nurse practitioners into Puerto Rican areas could be effective. Moreover, significant fiscal incentives are needed to encourage outpatient health care delivery and to download certain services from the hospital based setting.

Quality of Health Services and Medical Care

The quality of medical care for Puerto Ricans is marginal. There are two major issues here: 1) the health care infrastructure, i.e. the existing base of hospital, physicians, and outpatient services, is limited when dealing with the health care needs of Puerto Ricans; and 2) inadequate services are reflected, in part, by an excess morbidity and mortality for many medical disorders found within the Puerto Rican community.

The merging of quality of care data and health outcomes research would be extremely valuable in tracking changes in health care delivery and quality or outcome. Data to measure such criteria must be developed for Puerto Ricans as well as other Hispanic communities.

Cost of Medical Care

Aggregate costs of medical care continue to increase at a much greater rate than real GNP growth. Strategies at cost containment, in the aggregate, have not been successful during the last two decades. This increasing health care bill and the lack of successful cost containment has had two serious effects on Puerto Ricans.

First, medical out-of-pocket expenditures for Puerto Ricans have increased relative to family income and have had a greater impact on Puerto Ricans compared to the non-Hispanic population at large. This is due to lower average family incomes for Puerto Ricans. A second significant impact of this medical cost inflation is reflected in a decrease in relative program dollars, for those tax supported programs, which has not kept pace with demand. The impact of spiralling health care costs have been doubly serious for Puerto Ricans. Thus, significant fiscal incentives are needed to encourage outpatient care delivery, and to discontinue certain services from the hospital based setting.

AIDS and Drug Abuse

In the midst of this health care delivery strain for Puerto Ricans, comes a lethal and costly disease, AIDS. Data suggest that the AIDS pandemic is growing rapidly among the Puerto Rican population. Again, the number of AIDS cases in the Puerto Rican community is increasing for women and children in addition to substance abusers. Drug abuse continues to plague many Puerto Rican communities.

This presents a challenge to the current health care delivery system. Targeted resources will be needed for AIDS prevention, education, and treatment for Puerto Ricans. New programs designed to halt the spread of drug abuse which utilize the resources of churches, schools and the private sector are necessary.

ADDITIONAL RECOMMENDATIONS

- ◆ An emphasis on primary and preventive services (including comprehensive reproductive services) to help move the focus of the health care system away from treating illness and toward maintaining good health;
- ◆ Greater services for infant care and childhood immunizations;
- ◆ Support services needed by low income families and children with special health care needs. Such services may include home visiting, respite care, early intervention, social work, nutritional services, and language translation assistance;
- ◆ Funding for health care providers, such as community health centers, which attend to the needs of underserved populations;
- ◆ Medical services which include mental health and substance abuse treatment services;
- ◆ Support for hospitals and clinics with staff who understand the distinctiveness of the Puerto Rican community and who are culturally sensitive to Puerto Rican issues, such as kinship and family; and
- ◆ An increase in Medicaid benefits provided to residents of Puerto Rico.

CONCLUSIONS

The problem concerning Puerto Rican health care needs in the States has reached epidemic proportions. Access to adequate health care services is the single greatest challenge facing the Puerto Rican community, particularly with regards to physician, hospital, and ambulatory care services. Notwithstanding, the quality of medical care as well as spiralling health care costs are very important issues for Puerto Ricans. The coordination of medical care, emphasis on AIDS and drug abuse, and health manpower requirements for Puerto Ricans in underserved areas can have a major impact on health services in America and thus require immediate attention.

The federal government, specifically the Department of Health and Human Services, should target strategies to address each of these issues in reducing the problems for the Puerto Rican community. Federal support and federal initiatives are needed to improve the health status of Puerto Ricans.

Once again thank you for the opportunity to submit a written statement. Any questions would be welcomed.

Please direct any questions to:
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(202) 223-3915, ext. 29

CRAIG THOMAS
WYOMING, AT LARGE

WASHINGTON OFFICE
LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-8001
(202) 225-2311

Congress of the United States
House of Representatives
Washington, DC 20515-5001

STATEMENT FOR THE RECORD BY THE HONORABLE CRAIG THOMAS (AL-WY)
HEARING BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
HEALTH CARE SERVICE DELIVERY INFRASTRUCTURE
IN INNER-CITY AND RURAL COMMUNITIES

JUNE 24, 1993
10:00 A.M.
1310-A LONGWORTH

Mr. Chairman, thank you for holding this vital hearing. I appreciate your dedicated efforts in addressing health care reform head on. I'm sure we can all attest to the dilemma facing both rural and urban communities, and the need to reform it cannot be understated.

Americans spend nearly \$900 billion annually on health care. And despite all this expense, costs continue to skyrocket. Rural areas, however, also face the problem of access, which can often be a greater hinderance to quality care than cost itself.

Twenty-five percent of all Americans live in rural areas. The profile of rural populations consists largely of senior citizens and citizens living below the poverty line. They are often self-employed or employed by small businesses and, as a result, are usually left out of the traditional employment-based

health insurance system. The occupations differ vastly from metropolitan cities. There is higher agricultural and mineral excavation employment -- both highly hazardous.

Rural communities have a difficult time recruiting health care personnel. It is a known fact that practitioners must be generalists and services must be generic. Rural areas are still in the process of rearranging a basic system of care that is available and accessible to all residents.

The health care dilemma in these communities cannot be easily addressed by one "black or white" plan. Some policy experts advocate a nationalized system as the solution for universal access, while others advocate a "managed competition" approach. Neither of these systems, however, is adaptable to the circumstances confronted daily in rural areas.

In our state of Wyoming, we face a severe health professional shortage. We also encounter severe weather conditions that can change without a moment's notice, geographic boundaries that add an extra 100 miles to the drive to the nearest hospital, and virtually no public transportation. Health care reform to us means more than simply issuing a "health care security card".

There is no set model for all states. Each community has its own limitations and any national plan must be flexible enough

to help communities overcome their access barriers.

Wyoming's health care providers are forced to work as a team. Our state encompasses 97,000 square miles with a population of 490,000 people. There are twenty-six sole community hospitals ranging from fifteen acute care beds in smaller towns to 282 beds in bigger towns. We depend a great deal upon primary care physicians, mid-level practitioners and clinics.

Due to low inpatient stays and high regulatory costs, many communities cannot support a full-service hospital. They need the capability to down size but still keep some form of 24-hour emergency medical service available for stabilization. For the most part, ambulances and air transport services fill the role in moving patients to larger, specialized facilities. There are many conditions, however, that make it difficult to travel and advanced telecommunications systems are becoming the linchpin for the rural health care delivery system. For example, a mid-level practitioner at a primary care clinic in Yellowstone National Park has the technology to link up with a specialist at the University of Utah Medical Center. Such instances are rare but vital and Congress must change anti-trust laws to facilitate other similar cooperative arrangements.

Since entering Congress, I have advocated that states be proactive in developing a health care delivery system that fits

their needs. The idea that what works well inside the Beltway will work well in Basin, Wyoming, is frankly, wrong.

There's been a great deal of talk lately about creating a one-size-fits-all program, called "managed competition." In the event this passes as the national model, my bill, H.R. 1976, the "Comprehensive Health and Rural Equality Act," provides an exemption for rural states. The New England Journal of Medicine found towns need at least 180,000 people to support the most basic managed care program. The biggest town in Wyoming -- Cheyenne -- has a population of 50,000. Obviously, my state will not fit in a federally managed care system.

My bill, not only maintains the vital flexibility rural areas require, it also provides a basic set of benefits to every American. More important, it's funded by the strengths of the private sector without an increase in the deficit or taxes.

The "Comprehensive Health and Rural Equality Act" sets a flexible framework for all states to use individually. It fundamentally reforms the insurance industry by prohibiting cancellation, providing portability and controlling costs.

Furthermore, it reaches low-income folks by supplying vouchers for a basic benefit package. This will help eliminate cost-shifting in the health care industry. It will also provide families with the means to receive annual checkups than be forced

to wait for a costly emergency room visit.

Right now, there are too many conflicting forces involved, making it difficult for businesses to purchase insurance for their employees. My bill protects small business and encourages more to grow. It provides a full, 100% deduction to the self-employed and invites small businesses to form purchasing pools. These are the types of incentives needed to make businesses more competitive -- not additional mandates.

If we want to cut rising health care costs, we must re-evaluate the current incentives. To cut costs, we must overturn the old way of thinking -- that more means better. To accomplish this, we must encourage a greater use of outcomes research and enact tort reform. Both of these measures go hand in hand because the medical community can't re-evaluate outdated treatments with the constant threat of lawsuits. Administrative reform is also needed to cut the paperwork maze, such as uniform claims and electronic billing.

Mr. Chairman, I hope these solutions will be given serious consideration by the Subcommittee. Congress cannot afford to implement a national health care program that discriminates against rural areas. Rural people deserve access to quality health care just as much as the inner cities. And any comprehensive health care plan must take that into account.

Thank you again, Mr. Chairman, for holding this important hearing. I appreciate your interest in rural areas and look forward to exchanging other recommendations to improve our nation's health care delivery sector.

IMPLEMENTATION OF A NATIONAL HEALTH BUDGET

TUESDAY, JULY 13, 1993

**HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
*Washington, D.C.***

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1310A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JULY 2, 1993

PRESS RELEASE #17
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
HEALTH CARE REFORM: IMPLEMENTATION OF A NATIONAL HEALTH BUDGET

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health care reform focusing on the implementation of a national health budget. The hearing will be held on Tuesday, July 13, 1993, beginning at 10:00 a.m., in room 1310A Longworth House Office Building.

In announcing the hearing, Chairman Stark stated: "Setting and enforcing a national budget for health care is a necessary component of any plan that is serious about controlling the runaway inflation in health costs."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The Prospective Payment Review Commission (PropAC) and the Physician Payment Review Commission (PPRC) are non-partisan Congressional advisory commissions. Established in 1983 and 1988, respectively, these two Commissions provide studies and reports to the Congress on issues relating to Medicare payments to hospitals and physicians as well as other health care financing issues.

In December 1992, each Commission was requested to conduct a study of issues in the implementation of a national health budget as it relates to institutional and professional services.

Specifically, the Commissions' analyses were requested to include consideration of issues involved in the:

- * Allocation of a national budget among types of health care services;
- * Availability of timely data to support the process for establishing and allocating the national budget; and
- * Establishment of maximum payment rates for enforcing the budgetary limits.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, July 27, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

(MORE)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will ~~not~~ be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning.

Today the subcommittee continues its series of hearings on health care reform with a discussion of the implementation of a national budget.

Much of the health care reform debate revolves around questions of how to limit growth in health care expenditures to a more reasonable level. Currently, health care costs are rising at about 12 percent per year. At this rate, health care costs will grow from their current level of 14 percent of the GDP to more than 18 percent by the end of the decade.

In its simplest form, the purpose of a national health budget is to establish a goal for a more reasonable rate of growth in health spending. While there is no black or white test of how much we should spend on health, there is a broad consensus that the current rate of growth can and must be slowed substantially.

While conceptually simple, implementation of a national health budget is complex and raises numerous issues, including: How should the budget be established? What is an appropriate rate of growth? What separate goals should be established by provider type, by State, and by type of insurance plan? What data are necessary to sets and monitor compliance with the budget? And how must the budget be enforced?

The choices made on these and many other issues would have very important effects on hospitals, physicians and other health care providers. If carefully designed, the health budget could create positive incentives that would improve the delivery of care. Primary care services could be emphasized. Underserved areas could be given the freedom to increase spending to improve access. Growth in health resources in areas with overcapacity could be restrained.

On the other hand, if poorly designed, a budget could exacerbate many of the cost and access problems that already plague our health care system.

In December of last year, I requested the Prospective Payment Assessment Commission and the Physician Payment Review Commission to study the issues involved in the design and implementation of a national health budget. The minority ranking member and staff of the committee were advised of this request, and today the Commissions are releasing these reports.

I would like to commend the two Commissions for their careful and thorough analysis of the many issues involved.

Today's hearing will explore the complex issues raised by these reports. I hope that this information will help the subcommittee design legislation to control rising health care costs.

I recognize the distinguished ranking member, Mr. Thomas, for an opening statement.

Mr. THOMAS. Thank you, Mr. Chairman. I look forward to the testimony and, as was apparent from the Washington Post Health section this morning, the structure has been completed, the task force has been disbanded, and only the multiple choice questions confront the administration in terms of a mix-and-match. So I appreciate your last line about the subcommittee designing legislation to control rising health care costs.

Perhaps we need to anticipate the type of amendments that will be made in order to make sure that we control health care costs without something that may be conceptually simple but won't work. I look forward to the testimony.

Chairman STARK. Are there any other comments or statements? If not, we will begin. We have two witnesses. I would like to welcome Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission, ProPAC; and Dr. John Eisenberg, Chairman of the Physician Payment Review Commission, also known as PPRC.

They are accompanied by the Executive Directors of their two Commissions, Don Young for ProPAC, and Paul Ginsburg for PPRC.

Before you start your testimony, I would like to thank both Commissions for the effort put into these studies. The reports, I am sure, will be closely studied as we proceed through the process of developing health care reform legislation over the next few months.

The written reports can be obtained by contacting the commissions. Now, Stuart, you can lead off if you want. Please summarize or expand on your report in any manner that you are comfortable.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ALTMAN. Thank you, Mr. Chairman.

It is again a pleasure for us to appear before this committee. We have had a very good and productive relationship over the past 10 years and we all look forward to this.

I want to emphasize something that you said in your opening remarks, Mr. Chairman, and that is this was a request of the subcommittee and yourself, and we take those requests very seriously and we proceeded to move forward to make sure that we addressed the issues involved but in no case did we as a Commission vote on whether we believe this is a good idea or not, or whether there are other ways that might be better.

Rather we attempted to look at the technical aspects of what a global budgeting system or expenditure limit might look like under different assumptions and we focused on institutional care in the hospital, in the nursing home, and in ambulatory settings, and my colleagues focused more on the physician side and physician services.

Let me just make a few general points and then leave as much time as possible for comments and discussion.

The idea of a global budgeting system is in use in various countries throughout the world and subsets of it are in use in parts of the United States such as the VA or the experimental program in Rochester or through overall capitated systems, whether a Kaiser or Harvard's health plan.

But no country or system within this country is as complex as our whole health care system is and what we are talking about here far exceeds that of any other group and therefore any attempt on our part to say that we know what would happen would be pure conjecture.

We have some pieces of information that suggest if we do this, that would happen, but no country or subpart of our country has ever embarked on an effort quite as complicated.

As you pointed out though, this is a serious issue. Health care costs are growing very rapidly and could approach 20 percent of our gross national product some time in the early part of the next decade. We don't understand what implications that would have on our economy.

We can already feel the negative pulls that are occurring as a result of one sector taking such a large bite, but it begins to compound as you grow to 20 to 25 percent of GDP. So it is a serious issue and we addressed it as such.

In your request, you did not make the assumption that a global budget would necessarily be accompanied by medical care reform, and so we addressed this issue both without reform and with reform. But I want to state up front a statement which I have made before this committee before, and which I think is shared by my fellow commissioners: If we attempt to introduce a global budget or expenditure limit before we put in place true comprehensive health care coverage for all Americans, we have to guard against the possibility that one group will be heavily discriminated against, and that is the uninsured.

This is no trivial issue because there is no question in my mind that if a provider group is faced with a very tight limit on its budget, it is naturally going to go to the weakest link in its service delivery and invariably those will be the people that don't pay for care. We have put that in our report and I want to emphasize it again this morning.

We did attempt in our discussions to talk about it both in the context of prior—to reform as well as after reform.

The other issue which I am sure we will talk about is the relative role of the Federal Government versus the States. We did not come down one way or the other on which is the better way to go. We looked at the implications of a Federal and State system and talked about the possibility that you could have State flexibility within a Federal system. There are clearly advantages and disadvantages of going one way or the other and I am sure that will come out in our discussions.

Now when one goes about thinking about a global budgeting system, obviously the first issue is establishing the budget itself, how much should that budget be and how do you set it up.

Later in our report we talk about focusing on that global budget with regard to certain benchmarks. The one that is often used is GNP or now we are getting very sophisticated in this country, we talk about GDP. We should do a little test to see how many people know the difference, including me. So GDP is often used as a benchmark.

Some people talk about limiting spending to CPI, sounds like a simple thing to do.

I want to make clear limiting health care expenditures to CPI is a serious reduction in expenditures, more serious than linking it to GDP. We looked at CPI, GDP plus population growth, and at some phase in of GDP as a benchmark. I will talk more about the impli-

cations of all three later. That is an important issue that needs to be addressed.

The second is, once you have established a national limit, however we have done it, through boards, through a board with the Congress, with the President, based on a ouija board, the next question becomes how do you allocate that expenditure down appropriately to levels below the Federal Government. Most often the suggestion is first allocate it down to States and then to regions. The alternative, which other countries do—all other countries one way or another, allocate it from the Federal Government directly to providers.

In the case of Canada, it goes to the provinces, but they in some sense act like the Federal Government here. They are the real deciding factor. Then they go directly to subsectors, the hospital sector, the physician sector, the ambulatory sector, and often directly to providers in the form of budgets.

We looked at three ways of doing this. One is through a managed competition environment with controls on premiums. That is the most global.

The second approach is to use a ratesetting system with appropriate adjustments for volume.

The third is to go to budgets. The simplest system frankly is to go to budgets. That is what most other countries do, particularly for hospital care. However, it does bring with it a very restricted view of how you look at the health system, because once you go down budget lines, you then have to be very conscious of the flexibility between budget lines, and it is true that other countries have not been nearly as flexible as we have in terms of the changes in their delivery systems.

They have much more rigid systems. They use their hospitals much more than we do. They keep people in the hospital much longer.

Physicians often cannot practice both on the outpatient side and on the inpatient side. There are barriers that are established. So if you go the budget approach, you wind up with a simpler system, but a more rigid system.

We talked about premium limits. Some people talk about premium limits without a managed competition environment. The fear that many have is if you establish a premium limit under the current situation where insurance companies lack the real controls, and you establish tough limits, what you are really doing is asking those insurance companies to go out of business.

Some might think that is not a bad way to go, but you have to realize that effectively most of our financing mechanisms don't have the capacity to control spending. So we talked about premium limits in a new environment in much more a managed competition environment where hopefully they would have such capacity. We also talked about ratesetting and budget systems.

Much will be said in the ensuing discussion about the ability of States or the wisdom of States to control spending, and we talked about the data that would be needed to do that. I want to say a few things about data. There is no question that much more information would be needed to really effectively establish such a system, particularly if it is at State or regional level. We have much

more information at the national level than at the State and we would need to embark on a very major data collection effort.

It is also fair to say that other countries have global budgets with much less information than we have today. So if the call came down from the Congress and the President to introduce a global budgeting system, I think we could begin that process immediately, recognizing that in the beginning it would be far cruder than we would ultimately want, and the task would be to develop the data as we moved along.

Others would suggest that you develop the data first, and maybe that is the right way to go, but I want to make clear that it is possible to introduce a cruder form of a global budgeting system as you introduce more effective data.

Let me now turn to the issue of prices and volume and the implications to this system. As I indicated, we looked at three approaches for focusing on global budgets in terms of limits. One is the inflation plus population growth. The second is the rate of the growth of the GDP; and third is a phasein of the GDP system.

If you look at table 1, which is on page 15 of our testimony, the most stringent of the three approaches is inflation plus population growth. In 1994, that would generate a savings from projected spending of about \$29 billion, or a reduction of 6.8 percent in spending.

The growth in GDP would generate a savings of about \$21 billion, or about 4.9 percent, and the phasein naturally would result in the lowest savings, \$7 billion, or a reduction of 1.7 percent.

If you extended these three over the 5-year period, inflation plus population, growth would generate a savings of \$495 billion or almost 20 percent reduction in spending. The growth in GDP would generate a savings of \$374 billion or a reduction of about 14½ percent and the phasein would reduce spending by about \$190 billion, or a reduction of 7.3 percent.

Remember, by 1998, we are talking about a system which is approaching \$1.5 trillion to \$1.6 trillion so we are dealing with these numbers in relationship to that amount.

My comment and the comment in the testimony about the disruptive nature of focusing on GDP relates to the year-to-year fluctuations in GDP, and one should appreciate the fact that health care spending does not have the same trend factors as GDP.

As a matter of fact, health care has been on its own trajectory, quite different from the bouncing around of our GDP numbers. If you forced health care spending to respond to the exact fluctuations in GDP, you would be leading to a rather disruptive set of spending patterns.

Therefore in our testimony we make that comment and suggest if we are going to use GDP, we should talk about some average growth rate over a period of time or smoothing. We expect that over the next decade the average growth of GDP will be 5 percent and a GDP spending target would be follow GDP, the target would bounce around, going from 8 to 2 or 7 to 4. You are, I think, asking for a very complicated and disruptive settle system. That is what we meant. But we do believe that a better way to do that would be to have some averaging.

Interestingly enough, inflation plus population growth has very similar trend lines to health care spending although the gap is different. So in terms of rates of growth, inflation plus population is a much better mirror of health care spending although the gap between the two is very wide.

You may want to have GDP as a level and inflation plus population as a rate of change, some combination, which we didn't look into. We looked at and you have in the testimony our tables looking at the different sectors of institutional spending and the implications these different constraints would have on these different sectors.

We looked at the hospital inpatient sector, the hospital outpatient sector, nursing facilities and home care, and we looked at what would be the implications of reaching the different targets that I talked about, GDP or inflation, considering the volume and price reductions that would be necessary.

Let me say these are just illustrative. First, this is not what would happen, and I would say this is not what should happen because you want to give more flexibility to tradeoffs between sectors. We found this to be a very helpful exercise to tell you where the constraints would begin to bite. For example, this country, as you know well, has been quite restrictive in terms of the rate of growth of hospital inpatient care. As a matter of fact, for many years we saw actual reductions in the rate of growth of inpatient care.

Therefore, volume is not an issue and if we were to keep volume as forecasted, and price increases held to an economy-wide inflation, we would see the spending reduction to be quite dramatic to 1.6 percent.

On the other hand, if you allowed volume to grow for the outpatient side and held price to inflation, that would generate a spending increase of 8.3 percent, suggesting that if you have to get the 8.3 percent increase down to the GDP level of 4.9 percent, you will have to do some serious reductions in volume for hospital outpatient care, much more than the other sectors because that is where the growth is.

So the point in our table, table 2, is that simply relying on price alone may work OK for inpatient care and maybe even nursing care, but not for hospital outpatient care, and I am sure John and Paul will tell you the same thing is true for other aspects of ambulatory care.

Finally, let's say a couple of things about the implications of all this. To meet a target based on GDP growth would require substantial reductions in the currently forecasted volume or price increases, and probably both. Consequently a global budget is likely to have a substantial effect on the payers and the providers of health care and could affect both access and quality.

I don't think we ought to be lulled into the expectation that we can simply do this and not expect that we would have implications both for access and quality.

Hopefully, we would do it in such a judicious manner that impacts on quality would be negligible, but if we are not careful they could be substantial and other countries have had to deal with that.

If we would implement the global budget on plans, no question about it we would see a consolidation of the insurance industry. In addition, the plans would probably apply financial pressure to providers to encourage them to contain costs.

Without other reforms, however, payers might respond to the budget limits by restricting service access for high-use individuals or refusing to insure high-risk individuals. So this is one of the issues that we focused on.

If we introduce a global budget with no restrictions and no reforms, we have to watch out not only for people that are uninsured, but for people who now use a lot of health care services.

The effects of global budget on access to care could also be substantial, but we want to make clear here that any reductions in expenditures, whether it comes about from global budget or from competitive forces or from the force of some strange being, will have an impact.

It is wrong to say global budgets are the evil. The question here is if you are going to take \$300 or \$400 billion over 5 years out of an industry which is now growing to almost \$1 trillion a year, it is going to have implications, and the question becomes how do you minimize the adverse consequences of those implications.

We talked about access and quality in our report. So in conclusion, Mr. Chairman, we have tried to anticipate the issues involved in a global budget with respect to institutional care. We have pointed out different approaches that might be taken, and we have laid out what the implications of going down road A versus B would be.

As I said in the beginning, our charge was to just lay out these implications and not try to make the tough calls that you will have to make on whether it is a good idea or not.

Thank you very much.

Chairman STARK. Thank you very much, Stuart.

[The prepared statement follows:]

**STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN,
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION**

Good Morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission. I am accompanied today by Dr. Donald Young, the Commission's Executive Director. I am pleased to be here this morning to discuss the Commission's report on global budgeting, requested by this subcommittee. Our report discusses the issues involved in designing and implementing a global budget for health care spending. As you requested, our report focuses on hospitals and other institutional providers of health care.

As you know, Mr. Chairman, the uncontrolled growth of health care spending has plagued this country for almost three decades. In 1965, the nation spent \$42 billion on health care. By 1980, expenditures had increased to \$250 billion--about a 500 percent increase--and estimates for 1992 were \$832 billion. The future looks just as bleak; total expenditures are projected to reach \$1.6 trillion by the year 2000, almost doubling in fewer than 10 years. The relentless rise in spending has intensified the search for methods to control health costs.

A global budget has been suggested as one way to control health care costs and limit health spending. While the term "global budget" has been defined in various ways, for purposes of our report a global budget is an overall spending target or limit that constrains the price and the quantity of services provided. The budget could apply to all health care expenditures or expenditures for only certain services or providers. Similarly, the budget could apply to the entire population or only certain groups. While the form may vary, the overarching goal of a global budget is to limit total health care expenditures with minimal impact on access and quality of care.

The Commission's report sets forth the major issues that must be addressed in designing and implementing a global budget. Clearly, reforming our system of financing health care services--as is being discussed by this subcommittee and others--would affect the design and implementation of a global budget. The report, therefore, highlights specific global budget features related to three potential comprehensive financing reform options--managed competition and premium limits, rate setting, and provider budgets. These examples, however, are merely illustrative; our analysis of global budget issues is not dependent on any specific reform proposal.

The report also discusses data requirements necessary to implement and administer a global budget, as well as the potential effects of a global budget on health care spending and access and quality of care.

I would like to emphasize, Mr. Chairman, that you did not ask for--and our report does not include--Commission recommendations on the appropriateness of a global budget. Neither does the report endorse any particular budget design features. Rather, we have laid out the important issues that must be addressed in developing a global budget, the information available to help choose among design options, and the range of potential consequences of those decisions. I now would like to briefly highlight several of the issues addressed in our report.

GLOBAL BUDGET EXPERIENCE

To better understand the concept of a global budget, we first looked at the global budget experiences of several nations, as well as the application of global budgets in limited situations in the U.S. Our report summarizes the global budgeting systems in Germany, Great Britain, the Netherlands, and Ontario, Canada, as well as the global budgeting systems of the Department of Veterans Affairs, the Hospital Experimental Payment Program in Rochester, New York, and a private capitated health care delivery system.

There are several lessons we learned from the systems we studied. First, there are many different ways a global budget can be put in place. Second, most of the foreign systems we examined cover the expenditures for virtually the entire population

of each country and usually include a wide array of services. In addition, budgets generally are established for the operating expenses of facilities; capital expenditures may or may not be incorporated under the budget. Budget authority tends to be centrally located, although in a few examples, several entities share this responsibility. Finally, negotiations among the affected parties--including the government, payers, and providers--play an important role in determining specific provider payments.

U.S. HEALTH CARE SYSTEM

One of the most important lessons we learned from our examination of the foreign experience, Mr. Chairman, is the importance of designing a global budget that complements the overall health care financing and delivery system. The U.S. health care system is unlike the systems in any of the countries that have global budgets. Thus, while we can learn from the foreign experience, we should not lull ourselves into thinking that we can create a global budget in the U.S. merely by copying a system from another country.

Our report summarizes a number of characteristics that distinguish the current U.S. health care system. These include the following:

- 13 percent of the American population is not covered by any form of health insurance;
- Most health insurance is linked to the workplace and is not portable between jobs;
- There are over a 1000 different insurers, offering different benefit plans and paying providers using a variety of payment methods; and
- There are thousands of health care facilities and providers of different types, with significant overlap in the ranges of services they offer.

In our report, Mr. Chairman, we did not assume that these characteristics would change in the near future. Because of these characteristics, however, implementing a global budget without other reforms of the health care system could cause major disruptions in the financing and delivery of health care services. For example, under budget limits, providers would have fewer opportunities to recover the costs of care they provided to uninsured persons from third-party payers and, therefore, might provide less uncompensated care. In addition, insurers would have incentives to restrict the use of services, by limiting benefits coverage or restricting access to certain providers or services. Health care reform, however, could alleviate many of these problems.

DESIGN AND IMPLEMENTATION ISSUES

Mr. Chairman, I now would like to turn to some of the specific global budget design issues that are discussed in our report. To effectively limit health care expenditures, a global budgeting system must perform three major functions:

- Establish an aggregate national budget amount or limit;

- Allocate budget authority at the national level, or through states or regional entities, to insurance plans or providers that will be responsible for achieving budget targets; and
- Link budget performance to the flow of funds in the health care financing system.

Several design issues, such as establishing the scope and amount of the budget, are independent of the underlying health care financing mechanism. Other issues, such as allocating the budget targets and linking budget performance to payment, need to be resolved in the context of the broader health care financing system. Our report discusses a range of options that could be considered to resolve all of these issues.

Establishing the Scope of a Global Budget

Establishing a national health care budget would require decisions about which populations, services, and providers to include. These decisions would have important implications regarding the effectiveness and administration of the budget. A more comprehensive budget would have better leverage to control expenditures; however, it also would be more difficult to implement and could require more extensive and precise data.

Decisions about who should be included under the budget could be defined in terms of current health care coverage. For example, the budget could include or exclude people covered under Medicare, Medicaid, and other public programs; subscribers of private insurers and plans; employees participating in self-insured employer-sponsored plans; and the uninsured population.

The types of services to be included under a global budget could be identified in several ways. The budget could include only services delivered by specific sectors of providers—such as hospitals or nursing facilities. Alternatively, the budget could include all services covered under traditional health insurance policies or a uniform benefits package.

Mr. Chairman, one important issue that would need to be resolved at an early stage is whether to let individuals purchase additional services in a covered category that would not be counted against the budget limit. Allowing health care expenditures outside of the budget system would create flexibility to accommodate changing health care needs and individual preferences, but it also could reduce the budget's potential effectiveness. Most foreign nations with global budgets, however, permit certain expenditures outside of the system without serious budgetary consequences. This decision would affect the administration, and potentially the effectiveness, of the global budget.

Allocating Budget Targets

How a budget is allocated and enforced would vary depending on the underlying financing system. Budget allocations could be made to insurance plans through limits on premiums. Alternatively, allocations could be made to providers through mandated rates on services or facility-level budgets.

The Federal government could make budget allocations directly, or it could delegate this authority to states or other regional entities. These entities would then be responsible for setting limits for plans or providers. Allowing states or other regional entities to allocate the budget limits would provide flexibility to reflect geographic differences in utilization, expenditures, and regulatory environments. On the other hand, de-centralized allocation methods could add to the complexity of the

system and perpetuate current unexplained differences in spending across geographic areas.

I will discuss budget allocation in more detail in a moment, when I discuss design issues under specific health care reform scenarios.

Linking Budget Performance to Providers

How budget performance is tied to health care payments is crucial in limiting expenditures. To be effective, a global budgeting system must establish a link between budget performance and receipt of current or future revenues. The appropriate feedback method would vary depending on whether allocations are made to plans or providers. For example, if allocations are made to plans in the form of premium limits, this feedback would occur automatically because the plans would lose money if their expenditures exceeded their target. If, on the other hand, the budget is allocated to providers and they exceed their budget target, sanctions may be necessary. One option would be to reduce their allocation update for the subsequent period.

Design Decisions Under Health Care Reform

In our report, we developed three scenarios to illustrate how global budget features might differ under alternative financing approaches. The three scenarios—managed competition and premium limits, rate setting with volume performance standards, and individual provider budgets—are similar to several health reform proposals that currently are being discussed. These scenarios, however, are not intended to be exhaustive of all health care reform possibilities; in fact, many variations on each example could be developed. Instead, they represent the broad range of potential global budget designs and the relationship between design decisions and the health care financing contexts in which they might be applied. I would like to briefly summarize each of these scenarios.

Managed Competition with Premium Limits—One approach to reforming the health care system would be to limit health insurance premium increases. Under a managed competition approach, a global budget could be allocated on a per capita basis directly to regional health authorities or to states who could allocate to regional health authorities. Each authority would negotiate with health plans—organized networks of insurers and providers—to provide care for its members for an agreed upon per capita premium rate. Premium limits could be implemented without the managed competition structure, but this option would pose unwieldy problems for many insurers who lack the controls to ensure expenditures stayed within budget limits.

One important issue under the managed competition approach is determining how to resolve problems that arise as plans negotiate with the regional authorities. In some areas, plans that believe they are unable to meet the limits would appeal to the regional authorities or states. Procedures and specific responsibilities for meeting the budget limits would have to be developed. The risk for not meeting the limits could reside with the health plans, or the states or other regional authorities. The health plans would have the most ability to contain costs; this option, however, would probably result in fewer plans and could raise concerns about those beneficiaries enrolled in plans unable to meet the budget limit. Another option would be to allocate the risk to states or other regional entities, which would have to generate additional revenue if the budget target was not met.

Rate Setting With Volume Performance Standards—Another method of allocating budget targets would be to establish sector-specific budget targets with per service payment rates adjusted for expected service volume. Providers would face two risks under this option. First, given fixed payment rates, their costs might exceed

their payments. Second, if volume increased more than anticipated, the rate of increase in their payment rates could be reduced for the subsequent year. Consequently, providers would have strong incentives to control both the costs and volume of health care services.

Individual Provider Budgets--The third health reform scenario included in our report would allocate budget targets to institutional providers in the form of facility-specific total budgets. Providers' budgets would have to be integrated with the underlying payment system. Payers could compensate providers using a variety of methods that could be adjusted periodically to match expected revenues with the allowed budget. As with a rate-setting system, providers would face the risk that their costs would exceed payments. They also could receive reduced payment updates for inappropriate volume increases.

Data Needs for Implementing and Administering a Global Budget

Other nations have developed global budgets with less data than currently is available in this country. Given the complexities of the American health care system, however, expanding the collection of health care utilization, revenue, and cost data would be desirable to improve budget allocations and evaluate the global budgeting system over time. Large-scale data collection and processing activities are already in place, although not in all areas or for all payers. A global budget, in the context of health care reform, could provide the impetus to streamline these activities and improve the quality and consistency of the information available, while also reducing overall administrative costs.

IMPLICATIONS FOR HEALTH CARE SPENDING

Mr. Chairman, I now would like to briefly discuss our report's findings concerning the implications of a global budget on health care spending. As you know, the primary objective of a global budget is to constrain the growth of health care expenditures below what it would be otherwise. The need for this restraint is clear. Spending for hospital inpatient and outpatient, nursing facility, and home health services has risen almost four-fold since 1980, from \$101 billion to an estimated \$383 billion in 1993. Under current policies, these expenditures are projected to increase to \$624 billion by 1998, or at an average annual increase of 10.2 percent.

The financial implications of a global budget on future health care spending depend upon the level of the initial spending target and subsequent allowed rates of increase in that target. To demonstrate a global budget's potential to control health care spending, ProPAC conducted two analyses. The first analysis looked at various options for setting budget limits and the savings possible under each option. The second analysis examined the relative contributions of price and volume of facility-based services to growth in total spending and estimated the price reductions that would be necessary to meet a budget growth target tied to the growth in the nation's gross domestic product (GDP).

I should note at this point, Mr. Chairman, that these analyses should not be viewed as predictions of the actual impact of a global budget. The real impact of any global budgeting system would depend on many factors other than the target rate of increase, including the scope of the budget, the speed and forcefulness with which it is implemented, and the nature of other health reforms implemented simultaneously. ProPAC's analyses are intended merely to illustrate the potential for reduced expenditure growth and to assess the importance of controlling both price and volume in achieving that potential.

Spending Implications of Alternative Growth Rates

ProPAC looked at three options for setting a target rate of increase for a global budget, based on projections by the Congressional Budget Office: inflation plus population growth, the rate of growth in GDP, and a phased-in application of a GDP growth target. Estimated savings were calculated by comparing these targets with expenditure projections for 1994 to 1998 in the absence of any cost-control measures. Table 1 shows the potential annual savings from each option. As you look at the figures, Mr. Chairman, remember that these savings would result from limiting increases in projected rates of growth for health care spending, not reductions in current spending levels.

Table 1. Potential Savings in Facility-Based Health Expenditures from Application of Alternative Global Budgeting Targets, 1994-1998 (In Billions)

Target	1994	1995	1996	1997	1998	Five-Year Total or Average
Inflation plus population growth ^a						
Savings (in billions) ^b	\$29	\$60	\$95	\$135	\$176	\$495
Reduction in forecasted spending	-6.8%	-13.0%	-18.6%	-23.8%	-28.4%	-19.2%
Growth in gross domestic product						
Savings ^b	\$21	\$44	\$71	\$102	\$137	\$374
Reduction in forecasted spending	-4.9%	-9.5%	-13.8%	-18.0%	-22.0%	-14.5%
Phased-in growth in gross domestic product ^c						
Savings ^b	\$7	\$17	\$32	\$54	\$80	\$190
Reduction in forecasted spending	-1.7%	-3.5%	-6.3%	-9.5%	-12.9%	-7.3%

^a Inflation and population growth combined multiplicatively to yield total growth rate. Inflation represented by the GDP deflator.

^b Includes hospital, nursing facility, and home health expenditures; independent ambulatory care facilities, such as ambulatory surgery or imaging centers, are excluded.

^c Forecasted expenditure increase minus 1 percent in 1994, minus 2 percent in 1995, and so forth, with GDP growth substituted when it becomes higher.

SOURCE: Health expenditures measured by the Health Care Financing Administration; these plus inflation, population, and GDP forecasted by the Congressional Budget Office.

Inflation Plus Population Growth--A global budget target based on economywide inflation plus population growth would limit the rate of increase in per capita health care spending to inflation, with no increase for new services, technological advances, or the changing needs of an aging population. Under this scenario, new services or cost increasing technological advances could be added only if their costs were offset by productivity improvements or reduced spending elsewhere in the health care system.

As you can see from Table 1, setting the global budget limit to the rate of inflation plus population growth would have a dramatic effect. Projected spending for hospital, nursing facility, and home health services would be reduced by \$29 billion below projected spending in the first year and \$495 billion over five years. This option is the most stringent target, allowing health care spending to increase at an average annual rate of 3.2 percent, a sharp reduction from the 10.2 percent health spending increase currently predicted.

GDP Growth Rate--Another approach to setting a global budget would be to limit spending increases to the rate of growth in GDP. GDP growth is a measure of how much more health care the economy can afford without sacrificing other goods and services. Health care spending as a share of GDP has grown from 9.2 percent in 1980 to 14 percent in 1992; by the year 2000, this share is projected to increase to 18.9 percent. As the share of GDP attributed to health care increases, relatively less funding is available for other desirable public or private goods and services.

As Table 1 indicates, setting a target rate of increase based on GDP growth would save \$21 billion in the first year and \$374 billion over the five-year period. Less savings would be expected compared to the inflation and population growth target because the GDP target includes the rise in economywide inflation and population

growth plus the projected rise in productivity across the economy. Nevertheless, spending growth would be sharply reduced to an annual rate of 4.9 percent.

Phased In GDP Growth Rate--Another option for setting a target rate of increase would be to phase in a GDP growth standard. This would ease the transition to lower spending growth for consumers and providers.

Under our phased-in scenario, the target rate of increase initially would be set one percentage point below currently projected health spending growth. Progressively larger reductions would be made in subsequent years, until the increase in health spending reached the GDP growth rate. As you would expect, this method would result in the least savings; \$7 billion in the first year and \$190 billion over the five year period. Even though this was the least stringent target examined, achieving savings of this magnitude would still require significant changes in the delivery of health care services.

Volume and Price Roles in Limiting Spending Increases

Health care spending reflects both the price of services as well as the volume of services sold. To better understand how the savings in the above scenarios would be achieved, we examined the relationship between the price and volume of health services. To control health spending, reductions must occur in the rate of growth of either price, volume, or both.

To test the volume and price reductions necessary to achieve a budget target based on GDP growth, we examined the expenditures associated with different price and volume assumptions compared to projected expenditures in each year. Two alternative assumptions about volume increases were used: 1) volume would grow at current projected levels, and 2) volume would be limited to population growth and aging. Three different assumptions about price increases were used: 1) prices would grow at the rate of economywide inflation, 2) prices would rise at the rate of inflation for goods and services that health care facilities buy (market basket increase), and 3) prices would increase at the rate of the market basket increase plus the rise in complexity of cases treated (case-mix change). The last measure is similar to the model ProPAC uses to recommend payment updates under Medicare. Table 2 shows the results of our analysis.

Assuming volume increases as forecasted, if prices increased at the rate of economywide inflation, five-year savings would be \$436 billion, well over the \$374 billion GDP growth target. Allowing prices to rise at the same rate as the market basket would not achieve the GDP target, with five-year savings of \$295 billion. An approach similar to ProPAC's model would result in the least savings, \$181 billion over five years.

The contribution of price and volume increases to total spending varies considerably across types of facilities. Consequently, a GDP growth target would have very different effects across types of facilities. For example, because the increase in hospital inpatient spending is due more to price than volume, reducing inpatient prices would result in significant savings. To achieve the GDP growth target, inpatient prices could rise at an annual rate of 5.7 percent for the five-year period. In contrast, spending increases for hospital outpatient services are driven by volume increases; to reach the GDP growth target in this sector--without limiting volume--would require reducing outpatient prices by almost 1 percent annually for five years.

Table 2. Impact of Alternative Price and Volume Assumptions on Success In Meeting a Global Budget Based on GDP Growth, by Sector, 1994-1998

Measure	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Hospital, Nursing Facility, and Home Health
Expenditure growth (annual increase)				
If gross domestic product target met	4.9%	4.9%	4.9%	4.9%
If volume growth as forecasted, and price increases held to:				
Economywide inflation ^a	1.6%	8.3%	4.4%	4.1%
Market basket increases ^b	3.5	10.4	6.9	6.3
ProPAC model updates ^c	5.1	12.1	8.6	8.0
If volume growth matched to population growth plus aging and price increases held to:				
Economywide inflation	3.7%	3.3%	4.6%	3.8%
Market basket increases	5.7	5.3	7.1	6.0
ProPAC model updates	7.4	6.9	8.8	7.6
Savings (five-year total, in billions)				
If gross domestic product target met	\$113	\$160	\$58	\$374
If volume growth as forecasted and price increases held to:				
Economywide inflation	\$239	\$111	\$67	\$436
Market basket increases	173	78	35	295
ProPAC model updates	117	51	12	181
If volume growth matched to population growth plus aging and price increases held to:				
Economywide inflation	\$161	\$184	\$64	\$454
Market basket increases	89	157	33	314
ProPAC model updates	29	134	9	202

Note: In simulating the effect of price growth benchmarks, the lower of the benchmark or forecasted increase in payment per day or visit was used.

^a Represented by the GDP deflator.

^b Market baskets for hospital, nursing facility, and home health input prices developed by the Health Care Financing Administration and forecasted by DRUM/Graw-Hill, Inc.

^c Market basket increase plus an estimate of real case-mix growth.

SOURCE: Health expenditures and the impact of aging on the use of services measured by the Health Care Financing Administration; these plus GDP forecasted by the Congressional Budget Office.

Because the volume of hospital inpatient services is on a declining trend, meeting a GDP-based global budget in this sector would be less difficult than for hospital outpatient and other facility services with rapidly growing volume. To recognize changing utilization across facility-based sectors, spending might be allowed to rise at a higher rate for some facilities than others.

I should point out, Mr. Chairman, that holding health spending to a constant share of each year's growth in GDP could be highly disruptive. As Figure 1 indicates, historically there has been little relationship between growth rates for GDP and facility-based health expenditures. This is because health spending is more dependent on individual needs and preferences than general economic growth. In 18 of the past 31 years, the trends have been in opposite directions. In the late 1980s, health care expenditures rose while GDP was falling. The gap between the growth in health spending and economic output was wider from 1990 through 1993 than in any other three-year period since health expenditures were first measured in 1960.

In addition to following a different growth trend than health care spending, GDP also fluctuates much more on a year-to-year basis. With this degree of annual variation it would be highly disruptive to require the raise in health spending to match GDP growth on an annual basis. One alternative approach would be to update the spending target based on the annual trend in economywide inflation plus population growth, adjusted upward to approximate long-term GDP growth. As Figure 2 indicates, the trend in a combined measure of inflation plus population growth follows the trend in facility-based health spending fairly closely. Thus, this approach would minimize annual spending variation and maintain health spending at a reasonably constant share of GDP. Another approach would be to set a target based on average

Figure 1. Annual Change in Facility-Based Health Spending and Gross Domestic Product, 1970-1992

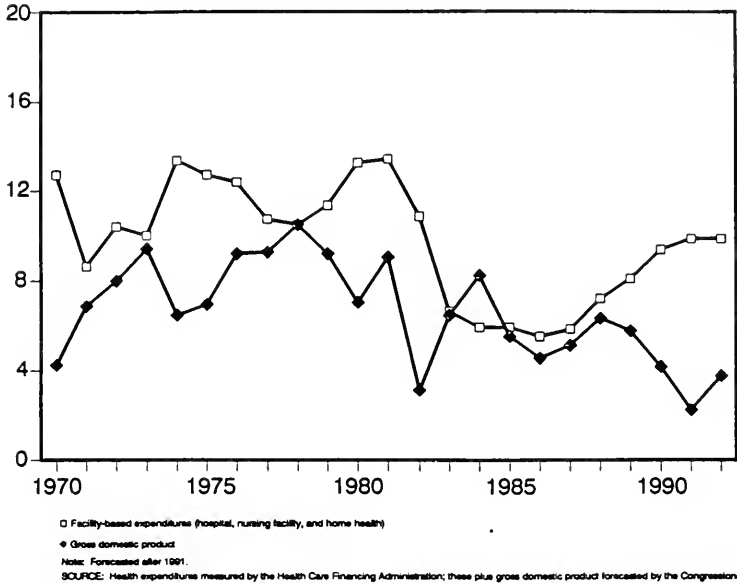
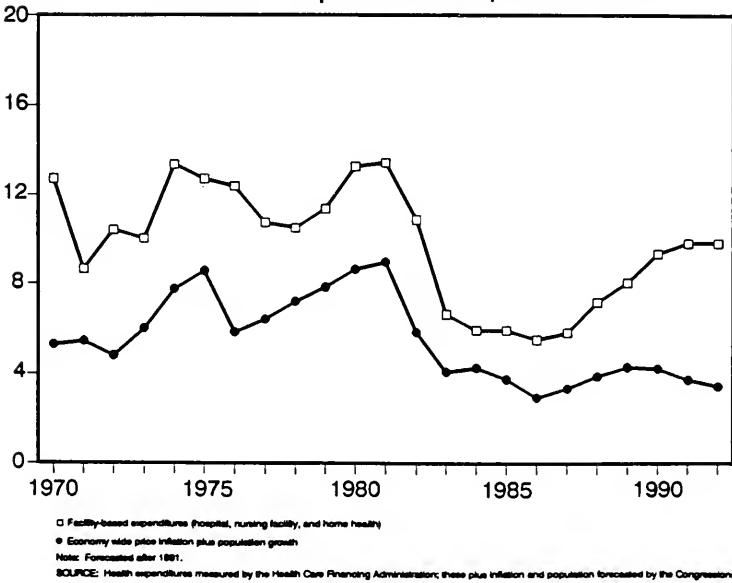


Figure 2. Annual Change in Facility-Based Health Spending and Inflation Plus Population Growth, 1970-1992



GDP growth over a longer period of time, such as ten years. ProPAC currently is examining different approaches that could relate health spending to GDP growth while avoiding the disruptive effects of annual fluctuations.

POTENTIAL EFFECTS

Mr. Chairman, as this discussion indicates, implementing a global budget offers the potential for substantial savings relative to the currently expected rise in facility-based health spending, but achieving this potential would not be an easy task. To meet a target based on GDP growth would require substantial reductions in the currently forecasted volume or price increases, and probably both. Consequently, a global budget is likely to have a substantial effect on payers and providers as well as on health care access and quality.

The impact of a global budget on payers would depend largely on the underlying health care financing system. If plans face a direct expenditure limit, as in a managed competition approach, they would be subject to heightened pressure to improve management practices to increase efficiency. Direct limits on plans would also probably lead to consolidation within the insurance industry. In addition, they probably would apply financial pressure to providers to encourage them to contain costs. Without other reforms, however, payers might respond to budget limits by restricting service access for high use individuals or refusing to insure high-risk individuals.

Providers would feel budget pressures directly if rate setting with volume performance standards or institutional budgets were implemented. Under either method, providers would have incentives to deliver care more efficiently. They also could choose, however, to reduce the number or types of services they deliver, or deliver services that are not included under the budget.

A global budget would not directly affect access to health care services. Access to care is determined by the financing and delivery system on which the budget is imposed. The effects of a global budget, therefore, would depend on other changes in health care financing and delivery related to health care reform, as well as the level of the budget target.

In terms of quality, there is no consensus on the relationship between health care expenditures and quality of care, except that there is a spending threshold below which quality care cannot be provided; however, that threshold has yet to be identified. Depending on other health care reforms and the responses of health care providers, limiting funds in the system could reduce quality by limiting needed services or curtailing quality-enhancing coordination activities. By contrast, a budget might also lead to improved quality if providers or insurers would promote a more appropriate mix of services to control expenditures and utilization, or if services were concentrated in fewer, more efficient facilities.

CONCLUSION

Mr. Chairman, as you and members of the subcommittee already know, finding a way to control health care spending is a difficult task. Implementing health care reform with a global budget for health care expenditures would represent a significant undertaking for the U.S. I should add, however, that any approach to health care reform, with or without a global budget, that successfully controls the growth in health care spending will have a substantial impact. We should expect substantial changes in the way health care services are financed and delivered as well as the role of government, the private insurance industry, the health care provider community, employers, and health care consumers. Our report sets forth the major issues that would need to be addressed if a global budget were to be implemented; however, resolving these issues will not be easy.

As we noted in our March Report to the Congress, ProPAC is concerned--as you are--about the spiraling costs of health care and the increasing number of uninsured persons. Health care costs are increasing at a rate that clearly is not sustainable in the long run. There will be difficult decisions to make. We would be pleased to continue working with this subcommittee and the Congress as you seek to implement solutions to the problems facing America's health care system.

I would be pleased to answer any questions you or other members of the subcommittee may have.

Chairman STARK. Dr. Eisenberg, welcome.

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. EISENBERG. Thank you, Mr. Chairman.

I am pleased to be here representing the Physician Payment Review Commission. As you said, Paul Ginsburg has joined me. Paul is the Executive Director of the Commission.

The report which we have submitted has been drafted by the Commission during the period since December when you asked for this report. The lead staff person was Jack Hoadley and I would like to give him credit for a tremendous amount of staff work that was put into this report.

Our position is very much like that of ProPAC. We received your request and read it carefully, and we have responded in the sense that this gives us an opportunity to assess the advantages and disadvantages and try to give some advice on how such a program might be implemented.

Throughout our report, we have said if expenditure limits were to be instituted, here are some of the conclusions that we have reached because we didn't think it appropriate for us to take a position at this point about whether global budgeting or expenditure limits is necessarily the right strategy or not. But this approach is consistent with the way in which the PPRC has worked and has tried to serve you in the past, first looking at issues, analyzing what the problems are, looking at what the options are that are being proposed, or coming up with options ourselves, looking at strengths and weaknesses of those, and subsequently making recommendations.

We have dealt with the relative value scale that way, Medicare volume performance standard that way, medical education that way, et cetera.

In responding to your request, we felt we would prefer to use the term "expenditure limits" rather than the term "global budgeting." It is more than just a subtle difference, we felt, because global budgeting expresses the sense that there is a fixed budget and that that is all that would be spent during a certain period of time, whereas the term expenditure limit establishes a target and then provides flexibility for the Congress in determining how to respond to whether or not that target was met or was exceeded.

As Stuart said on behalf of ProPAC, it really hasn't been our intention to endorse or criticize any position, but we have learned I think in PPRC from the past 7 years a number of experiences, especially through the Medicare fee schedule and the Medicare volume performance standard, that we think are instructive in thinking about global budgeting or expenditure limits.

In particular, those two innovations, the Medicare fee schedule and the Medicare volume performance standard, have given us an opportunity to see what can be done and what some of the implementation issues are when an expenditure limit is established and when fees are recommended.

What I will do is to basically summarize our report and try to make six principal points. The first point is that we felt that if ex-

penditure limits are going to be used, that they should relate spending growth per capita to the growth rate of the gross domestic product per capita, a point similar to that which Stuart alluded to. We felt it is very important if GDP is used as a benchmark to be sure that the historical spending baselines provide the starting point for those goals so that we could look back and see what the growth rate had been and try to see how far off that is from GDP growth.

For example, if we look at what the projections are from 1993 to 2000 for the gross domestic product, we have learned that the projections are that it will grow on average 5.8 percent, whereas the projections for health expenditures are that it will grow 9.8 percent. So there is a 4 percent difference between gross domestic product if we use that as a target per capita and the growth in health expenditures that we expect to have during the next 7 years.

The second recommendation or conclusion is that if rate setting is used to enforce these expenditure limits, that a relative value scale be used to establish those rates and that the relative value scale could be similar to the one that is the basic payment mechanism for physicians under the current Medicare system.

Similar to the Medicare system, it was our conclusion that the rate ought to be updated on an annual basis that adjusts for prior year spending similar to the way in which Medicare volume performance standards are currently dealt with.

We also came to the conclusion that the incentives or the bonuses or risk or penalties that physicians face ought to reflect not only expenditures for physician services, but also expenditures that physicians influence directly or even control, such as drugs or hospitalization.

We also want to point out that setting the fee is not the only way in which expenditure limits can be attained. Reducing administrative costs is one of those, and we would want to work with the Congress to look at ways other than changing the fees and other than changing the revenue that would go to the physicians to achieve these expenditure limits because we think there are a number of ways in which that might be done in addition to rate setting.

The third conclusion that we reached again begins with the caveat—if rate setting is used to enforce these expenditure limits—and I offer that caveat for each of these conclusions because we don't want to take the position that rate setting ought to be used to enforce the expenditures limits, but it is a possibility. So, if rate setting is used, we suggest that some health plans be exempt from this ratesetting requirement, that those health plans that would be exempt would be exempted on the basis of their meeting some Federal qualifications, and that they might be subjected to premium limits that would be keyed in some way to the growth in the gross domestic product.

Our fourth recommendation or conclusion is, if expenditure limits are adopted, that few categories be established for these expenditure limits.

As you look at the potential for various categories, one could look at hospitals or physicians or long-term care and there is the potential for subdividing those categories in a way that we think would

be excessive and injurious. So we believe the best thing to do would be to use as few categories as possible for the expenditure limits and that each would have a separate historical baseline that would be used to establish that category's rate of update based upon the baseline and whether or not it achieved its expenditure limit.

Our fifth conclusion has to do with expenditure limits established by States. We recognize the advantages of establishing expenditure limits by the States. It doesn't require that there be a national consensus. It takes into account some of the local idiosyncrasies or preferences and some of the local health care systems, the political environment in the State, and we see those as substantial advantages.

We do see some difficulties in establishing expenditure limits at the State level though, and there are several.

One is the issue of data to which Stuart alluded. We do believe that the data system that we have today is not what it should be and in some States it is not sufficient to establish an expenditure limit at the State level.

The second concern we have is that while some States have established cost containment systems that seem to be working or at least have the promise to work, there are other States which are not ready in our opinion at the present time to institute cost containment strategies that would enable them to be likely to live within an expenditure limit. That raises a number of very difficult implementation questions, such as what are you going to do with a State that doesn't live within its expenditure limits?

Does the excess come out of the State budget or does the Federal budget offer some sort of backup funding? Therefore, there are very serious questions that are raised about the State's ability to contain costs.

There are also concerns about border crossing. Our data suggest that 10 percent of services in the Medicare system are rendered across a State border and there are parts of this country, Kansas City, St. Louis, a number of regions where a substantial amount of border crossing exists. That is not an insurmountable issue, but it is a serious issue that would have to be dealt with if the system were to implement expenditure limits on a State basis.

The final conclusion is consistent with the recommendation that we made in our 1993 report, that more timely data and more accurate data are necessary. Stuart pointed out the fact that we shouldn't necessarily wait until the data are perfect before we implement a system. We agree with that, but we believe that better data are needed now. No matter what health care reform brings, and no matter whether we use an expenditure limit by State or not by State, better data are needed.

We recommended in our annual report this spring that we have a national data system. We suggested that we could start quickly with that system by laying out a strategy for obtaining the data that would be consistent with the current Medicare claims forms, collecting summary data and total spending by different payers, and setting a cutoff period whereby claims would have to be submitted.

We suspect that the problem with data is more serious for physician services than it is for hospital services. There are more serv-

ices, the different plans and the different kinds of data that are collected for physicians are more diverse, and we believe that the challenge will be greater in having half a million physicians collect data that are consistent than it might be in having hospitals collect data that are consistent.

Those are the conclusions that we reached, Mr. Chairman. We appreciate the opportunity to serve you and look forward to answering any questions that Members may have.

[The prepared statement follows:]

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN,
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to come before the Subcommittee to present the Physician Payment Review Commission's report, *Expenditure Limits: Design and Implementation Issues*. This report is submitted in response to a letter dated December 11, 1992, in which you requested that the Commission prepare an analysis of the "design and implementation of a global-budgeting system as it relates to physician and other professional health care services." Throughout the report, we often use the term "expenditure limits" to refer to the types of policies that might apply to physicians' services in a multiple-payer environment. This term implies an approach that, rather than applying a fixed budget, sets targets for the total amount to be spent by a category of providers, a state, or a health plan.

It was not the Commission's charge for this report to endorse or criticize any overall strategy for containing costs. Rather we were asked to comment on the design and implementation of a system of expenditure limits and rate setting. Should the Congress decide to write legislation taking such an approach to reform, we anticipate that our report will be helpful in resolving many of the details needed for designing and implementing such a system.

The Commission has learned a great deal over the past seven years from providing the Congress with recommendations on the design of Medicare physician payment reform and monitoring the implementation of those reforms. As a result, we believe that the Medicare Fee Schedule and the Volume Performance Standard system could be viewed as a model for a national global-budgeting system. The lessons learned from these policies provide a framework for many of the conclusions in our report.

Mr. Chairman, I would like to include in the record as part of my statement the executive summary of the Commission's report. It provides a full listing of the conclusions that the Commission has drawn from its work on this report. I would like to provide you with a few of the highlights.

In the report, we examined a variety of the core design issues that might arise in developing and implementing a system of expenditure limits enforced through rate setting. In that process, the Commission came to several specific conclusions:

- expenditure limits, if used, should relate spending growth per capita to the growth rate of the gross domestic product per capita, and historical spending baselines should provide the starting point for these goals;
- if rate setting is used to enforce expenditure limits, a relative value scale such as Medicare's should be the basic payment methodology for paying for all professional services, and physician payment rates should be updated with a default formula that adjusts for prior-year spending, including a share of the bonuses and penalties for changes in the volume of certain other types of services as well as physicians' services;
- if rate setting is used to enforce expenditure limits, some health plans should be exempt from the rate-setting requirements based on revised standards for federal qualification, and exempt plans should be subject to premium limits;
- if expenditure limits are adopted, relatively few categories should be established, and separate historical baselines should be established for each category based on trends for the years prior to the enactment of reform.

The Commission also looked at a number of design issues that would arise in allocating budgets to the states. Given the interest of many policymakers in a state-based approach to reform, we considered it important to analyze how expenditure limits might be allocated on a state-by-state basis. The virtue of such a system is that it would allow states to select an approach to cost containment that best fits the local health care and political environment and would mitigate the need to achieve a national consensus on which approach would be most effective. On the other hand, this flexibility would mean that 50 states would have to develop the expertise to design and implement the necessary cost-containment and data systems on a timely basis. Although the Commission did not draw specific conclusions on this issue, it was concerned that available data would restrict the ability of policymakers to establish spending allocations for states and to monitor whether those targets were met.

The effective operation of a system of expenditure limits and rate setting cannot be accomplished in the absence of timely and accurate data. The Commission has been studying data issues for the past several years and made recommendations to the Congress earlier this year in its *Annual Report to Congress*. There we called for legislation to create a national data system that would use regional carriers to collect data from plans and third-party payers. A federal agency or board would establish data standards and oversee the system. We went beyond those conclusions in this report by laying out a strategy for obtaining the data needed to implement reforms in the short term. Steps would include using Medicare's definitions and claims forms as a starting point for standardization, collecting summary data on total spending from all payers, and setting a cutoff period for claims submittal by all providers.

EXECUTIVE SUMMARY

In a letter dated December 11, 1992, the Chairman of the Subcommittee on Health of the House Committee on Ways and Means requested an analysis by the Commission of the "design and implementation of a global-budgeting system as it relates to physician and other professional health care services." The request specifically asks the Commission to include consideration of issues involved in the (1) allocation of a national budget among types of health care services, (2) availability of timely data to support the process for establishing and allocating the national budget, and (3) establishment of maximum payment rates for enforcing the budgetary limits.

The terms "global budgeting" and "expenditure limits" have come to be used somewhat interchangeably in the health system reform debate. While this report uses both terms at times, the Commission believes that the term "expenditure limits" is generally more appropriate when applied to physicians' services in the multiple-payer environment of the U.S. health system. Expenditure limits refer to targets established by the government for the total amount to be spent by a category of providers, a state, or a health plan.

It is not the Commission's charge or desire in this report to judge whether a system of expenditure limits enforced through rate setting is the most appropriate approach to cost containment in health system reform. Rather, in responding to the charge for this report, the Commission considers a variety of issues that occur in the design and implementation of such a system. It also considers potential design and implementation issues that would arise in a system that assigns expenditure limits to the states. The report continues with discussion and recommendations for a strategy to meet the data needs imposed by health system reform in both the long term and the short term. Finally, the impact of expenditure limits and rate setting on physicians' fees and incomes is assessed.

The Commission's experience with the design and implementation of Medicare physician payment reform provides the overall framework for this analysis. The issues that have arisen in designing and evaluating the Medicare Fee Schedule and the Volume Performance Standard system can be viewed as a model for a national global-budgeting system. The lessons of the Commission's work over the past seven years form the basis for many of the conclusions in this report.

OVERVIEW OF EXPENDITURE LIMITS

The principal objective of a system of expenditure limits is to control rising health costs. If strictly enforced, such a system would contain spending within the set limits. Depending on how targets are set, spending per capita could be constrained to standards such as the rate of growth of the gross domestic product per capita.

The design of a system of expenditure limits begins with three key elements: a determination of which health services are included in the global budget; the establishment of overall budget goals or targets for appropriate levels of spending, given a variety of objectives for achieving access, cost containment, and quality of care; and the establishment of baselines from which these annual targets are evaluated.

CONCLUSION

The Commission concludes that, if a system of global budgeting or expenditure limits is adopted, (1) the global budget should encompass all services that are included in a standard benefit package; (2) an overall goal should be established that relates spending growth per capita to the growth rate of the gross domestic product per capita;

and (3) historical spending baselines should provide the starting point for meeting these goals, with adjustments for the impact of changes in benefits and coverage that might result from health system reform as well as adjustments for demographic and other factors.

The government's interest in global budgeting should generally follow its financial interest, so that all services subsidized by government funds should be subject to expenditure limits. Setting a goal for the system of expenditure limits should take into account a standard such as gross domestic product per capita that reflects domestic national income and thus affordability for the nation. In moving from overall goals to specific numbers, it is important to look at a historical baseline for spending. Two kinds of adjustments could be made to the historical baseline. First, demographic and other adjustments could be made to reflect changes in total spending that would maintain the current level of services. Second, policymakers could choose to move the historical baseline in the direction of system goals -- including a potential decision that the current level of services was too high.

Once the overall goal or target is established, a mechanism should be selected for enforcing compliance with the target. Two mechanisms envisioned for enforcing expenditure limits are rate setting and premium limits. While the former approach is considered at length in this report, the Commission has determined that premium limits are outside the scope of this report, other than in the context of how managed-care plans would be treated in a system that relies primarily on rate setting.

SETTING RATES TO ACHIEVE EXPENDITURE LIMITS

One of the principal mechanisms for controlling spending is setting maximum payment rates for different categories of providers. The relationship between expenditures and rates, however, is not exact. Total expenditures are based on both prices and quantity; although the government can set rates, the quantity of services is determined both by judgments of physicians and patients' demands for care.

Expenditure Limits, Rate Setting, and Fee for Service

The challenge under a system that relies heavily on fee for service is how to link the rates paid per service to the system's expenditure limits, especially given that rate setting does not directly address the volume of services. Implementing rate setting involves at least three policy design decisions: determining the basic payment methodology to be used, establishing the method of setting rates and addressing volume in order to enforce the expenditure limits, and determining whether different payers may use different levels of payment. In each case, the experience of paying physicians under Medicare is instructive.

CONCLUSION

The Commission concludes that, if rate setting is used to enforce expenditure limits, (1) a uniformly applied resource-based relative value scale such as Medicare's should be the basic payment methodology for paying for all professional services; (2) physician payment rates should be updated with a default formula that adjusts for prior-year spending, and physicians should share the bonuses and penalties for changes in the volume of hospital admissions, laboratory tests, prescription drugs, and certain other types of services; and (3) payment levels for different payers should be set initially to be budget neutral for each type of payer, but such differences should be phased out over a period of years.

The use of Medicare's relative value scale in paying for professional services is already gaining increasingly broad acceptance in the private sector. Less straightforward is the decision of how to set payment levels (e.g., the conversion factor) to meet the expenditure limits. There are four basic approaches to addressing changes in the volume of services: an annual policy decision with a backup formula that incorporates an adjustment for prior-

year spending that diverges from the target; an annual policy decision without any explicit reconciliation of prior-year spending; expenditure caps or withholds that attempt to guarantee that the expenditure limit is met; and structured negotiations between payer representatives and physician representatives. While each of these approaches has merits, the Commission has concluded that the Medicare experience with the Volume Performance Standard builds a considerable case for this approach.

Determining the appropriate level of payment may be a difficult issue, given the wide divergence that currently exists among payers. Private payers pay physicians at rates that are between one-third and one-half above Medicare's, while Medicare rates are substantially above Medicaid's average rates. The Commission concludes that, although it would be highly disruptive to eliminate these differentials all at once, payment levels should be made equal over a period of years.

Expenditure Limits, Rate Setting, and Managed-Care Plans

Managed-care plans pose some difficult challenges for designing a system that enforces expenditure limits through rate setting. These organizations often contract with providers on the basis of units of payment other than fee for service. Forcing them to abandon payment mechanisms chosen as superior to fee-for-service payment would not be advisable. But if some services are paid outside the rate-setting mechanism, their relationship to the expenditure limit must be determined. Decisions include whether to count the payments for services exempted from rate setting in the expenditure limit and whether to have a separate enforcement mechanism for health plans that are outside the rate-setting system.

CONCLUSION

The Commission concludes that, if rate setting is used to enforce expenditure limits, (1) some health plans should be exempt from rate-setting requirements; (2) such exemptions should be based on standards for federal qualification, but these standards should be revised to account for changes in the ways that plans contract with physicians and manage care; (3) for those plans not subject to rate setting for at least some of their provider contracts, expenditure limits should be enforced through premium limits; and (4) premium limits should be calibrated to the same per-capita spending limits on which rate setting is based.

ALLOCATION OF EXPENDITURE LIMITS TO CATEGORIES

If rate setting is chosen as the primary enforcement mechanism, then it follows that national expenditure limits should be disaggregated into categories. There are both practical and policy reasons for doing this. Because payment methodologies generally vary by type of provider, it makes sense to calibrate those methods to an expenditure limit by category. From a policy perspective, separate expenditure limits would help focus cost-containment incentives on particular groups of providers. Allocating expenditure limits to categories, however, poses significant technical challenges in determining accurate historical baselines on which targets would be based. It also raises the concern that inappropriate categorization could lead to payment discrepancies and create inequities between different types of providers.

CONCLUSION

The Commission concludes that, if a system of expenditure limits and rate setting is adopted, (1) relatively few categories should be established, and categories should be based on the need both to give incentives to groups of providers and to keep most substitution of services within, rather than across, categories; (2) separate historical baselines should be established for each category based on trends for the years prior

to the enactment of reform; and (3) a process should be established for tracking substitutions across categories.

Several factors may affect how categories are used in a system of expenditure limits. Categories might be created to give policymakers the ability to differentiate annual rate updates as well as to focus incentives on different types of providers. In addition, categories might be designed to protect certain types of services or to reduce inappropriate substitution of services. In general, fewer categories will maintain more of the substitution within the categories. To prevent inequities, expenditure limits by categories should be designed with separate baselines that reflect historical patterns of spending. Changes in either the categories or the baselines will be difficult to determine; improved data on substitution of services would allow policymakers to make an informed judgment on when these changes are appropriate.

EXPENDITURE LIMITS BY STATES

Increasing interest has been expressed by some policymakers in giving the states a central role in running a reformed health system. Whereas some proposals would simply allow states to opt out of the national system, much as states are permitted to seek waivers from requirements posed by Medicare or Medicaid, other proposals would give the states a more central role in determining how costs are to be contained.

A state-based system has the advantage of allowing states to select an approach to cost containment that best fits the local health care and political environment. Such a system also mitigates the need to achieve a national consensus on which approach would be most effective, allowing state experimentation and greater flexibility in changing decisions over time.

On the other hand, this flexibility would mean that 50 states would have to develop the expertise to design and implement the necessary cost-containment and data systems. In addition, data considerations would make it very difficult for the federal government to implement such a system in the short term. Limited data are available on current state spending, and no reliable time series exists. Available data reveal substantial variations in spending among the states and substantial instability in year-to-year changes in those spending levels.

In particular, substantial variations in historical baselines for state spending would force federal policymakers to devise a strategy for addressing twofold to threefold spreads from the highest-spending states to the lowest. Policymakers would have to decide whether these differing levels are the right starting points for requiring states to control costs or whether states would be required to meet a common expenditure limit (with appropriate adjustments for demographic, input-cost, and other differences) after a period of years. In addition, the apparent year-to-year instability in state spending data raises a concern that states might be rewarded or penalized for shifts that represent only measurement inaccuracies.

A further concern is the ability of states to design cost-containment systems that can meet the targets assigned by the federal government. One particular issue is border crossing, where a state's residents obtain health services from out-of-state providers. To the extent that residents get a significant share of services elsewhere, the state's ability to control costs may be restricted.

DATA NEEDS FOR EXPENDITURE LIMITS AND RATE SETTING

Health system reform will inevitably pose substantial challenges to existing data systems. If expenditure limits serve primarily as a budgeting tool, the data required may consist only of expenditures, payment rates, and service frequencies. If separate limits are posed by category, by state, or for managed-care plans, then additional data elements would be needed. Historical data would be required for setting baselines, current data for monitoring compliance with targets, and future projections for setting targets and maximum payment rates.

Given the high stakes attached to the decisions that are based on these data, the Commission, in its *Annual Report to Congress 1993*, considered various alternative approaches and set forth a model for a national data system.

RECOMMENDATION

The Congress should enact legislation to create a national data system. Such a data system would draw on the Medicare model by using regional boards or carriers to collect raw data from individual plans and third-party payers. These boards or carriers would verify the accuracy and comparability of the data and aggregate summary information to be used by the local community and the federal government for various monitoring, quality improvement, and regulatory functions. A federal agency or board would establish basic data standards and oversee implementation of the system.

Whereas the Commission's recommendation looks primarily at a long-range strategy for a national data system, policymakers focusing on health system reform must answer more immediate questions about the short-term data needs of a reformed health system. Under a strategy that incorporates expenditure limits achieved through rate setting, policymakers would need to move quickly both to establish initial rates for private payers and to monitor expenditures to determine whether targets are achieved. Under such an interim data system, it should be possible to obtain adequate data for setting and enforcing expenditure limits.

CONCLUSION

The Commission concludes that development of an interim data system, to be used if expenditure limits and rate setting are adopted, can be accomplished with several steps: (1) Medicare's definitions and claims forms should be used as a starting point for standardization rules, including its specialty designations, its system of Unique Provider Identification Numbers, and its use of CPT codes; (2) sample data should be obtained from a subset of the larger payers, including both commercial insurers and Blue Cross Blue Shield plans, and should be evaluated for purposes of setting limits and estimating expenditure growth; (3) payers should be required to submit data summaries that show their total spending for health care services by provider type and be required to open their methodologies for obtaining these summaries to audit by the government or some external organization; and (4) a cutoff period should be set for claims submittal by all providers.

With respect to setting expenditure limits by states, the Commission's strategy for a national data system should in the future provide a basis for accurate estimates of state spending. In the interim, estimates of spending for services furnished by a state's providers are currently being revised by the Health Care Financing Administration. These estimates could be converted into estimates of spending on behalf of the state's residents if more accurate estimates of border crossing can be obtained.

POTENTIAL IMPACT OF EXPENDITURE LIMITS AND RATE SETTING

Any health system reform that incorporates expenditure limits and rate setting may have a substantial impact on the health system and on the providers and beneficiaries of health services. The Commission has examined the potential impact of such a reform on physicians, an area where it has particular expertise. The potential for savings is considerable if the relatively high fees paid by private insurers can be moved down toward the Medicare level.

Both fee levels and physicians' incomes are examined. First, the Commission estimated how fees for selected services would be expected to change under a broader application of Medicare's relative value scale. If both Medicare's relative value scale and its conversion factor are applied, fees for many surgical and diagnostic services would fall by as much as 50 percent to 70 percent, while even fees for office visits would be reduced somewhat. By contrast, if Medicare's relative value scale were applied but total payments were maintained at current private-sector levels, reductions for procedural services would be offset by increases for evaluation and management services.

In the second analysis, the Commission estimated how physicians' incomes would be affected by the application of Medicare's relative value scale to all payers under the same two scenarios. If both Medicare's relative value scale and Medicare's conversion factor are applied to all payers, procedure-based specialists would experience declines in income of roughly 40 percent, while family physicians and internists would move from the bottom of the income distribution to the middle. Similarly, if private payers maintained a budget-neutral conversion factor, primary care physicians would earn incomes comparable to many specialists. Physicians' incomes, however, would be considerably higher than under the first scenario.

Chairman STARK. I want to thank both of you and your staffs for venturing into these murky areas because it is something that the country is going to have to deal with and I presume we will have to deal with as we proceed.

Stop me if I am wrong, but it seems to me both of you say or I write in your testimony that you would feel we have a need for a uniform national data system that we can collect the data that is uniform across the country.

Is that a fair assessment of the positions of both Commissions?

Mr. ALTMAN. I think that is true; yes.

Dr. EISENBERG. Yes.

Chairman STARK. And that would be useful in any kind of a system that we have?

John, you indicate that you see some problems that you outlined in your testimony. But as I read your testimony, you see some advantages in going State by State in that you do not have to try for a national consensus, you can let each State decide what suits their needs. But then the real fight I suppose comes when you bring the expensive States down to the national average over time or do you bring the inexpensive States up. These changes have some political implications, whichever direction you choose?

Finally, when you cite our experience in the Medicaid program, you refer to that as a reason to suggest that perhaps, I think that we must have you say a critical role, a major role in monitoring access, quality, and I presume setting the standard from which States could ask for an option to remove themselves rather than vice versa.

Do you feel that strongly because that is an issue that will come up should we turn this all over to the States and sit and wait to see if a State fails to meet some standard and then move in later or set a national standard and a Federal budget, which I suppose would be per capita, and let States who choose present a program for opting out?

Do you want to comment on that?

Dr. EISENBERG. As you might imagine, we didn't take a position that one or the other of those alternatives would be better, but we did look at the relative advantages and disadvantages. There are some reasons for interstate differences in expenditures, and the more we learn about them, the more we learn that some of those differences might be appropriate—differences in practice costs, differences in cost of living, differences in demography. But those differences don't explain the threefold differences in medical expenditures we see across States.

So our sense is that over time, whichever system is used that we will need to gradually move toward more equity in per capita expenditure across States.

I suspect that could be done through either a national system or devolving the decisionmaking about how to organize it to the States. If we are talking about Federal expenditures in the case of Medicare, I think we would want to move toward more equity per capita across the States.

Chairman STARK. Stuart, I think you started out by saying the purpose of a budget is to change behavior. Could a national budget affect issues that discourage or reduce overcapacity in the hospital

industry, encourage more primary care physicians, provide access in rural or inner city areas?

Could some kind of a national budget program be useful in accomplishing those goals?

Mr. ALTMAN. I think some of them it might help and some it might make worse. To the extent that overcapacity in this country leads to higher prices being charged as opposed to lower prices, then the pressure, serious budget pressure I think would force this sector to behave more like other sectors in our economy and we are already seeing that, more price wars on the part of hospitals and even physicians as they attempt to get patients. We are beginning to see that.

The market is in its own strange way working more and we see it in Boston, where the Harvard teaching hospitals are more concerned than ever about filling their beds. We see it in Minnesota, in southern California, and we are seeing it around the country. So this overcapacity, faced with market pressures, is leading to some reductions in prices, but the capacity stays out there for a long time.

The question is will it by itself come down? I think the answer probably is yes, but it could take a long time. There are some who suggest that we are going to need—we should be moving to some form of restrictions on capacity or maybe the regions may want to have more restrictions than the market.

I think that on the overcapacity issue, the global budget would work. I believe the global budget will put more pressure on groups to expand the availability of primary care. But here you have to link up what the delivery system wants with the training capacity, and the training capacity is slow to respond to that. I think over time it too might adjust, but I would think we would be better served by having our educational system for physicians much more in line with where we see the need, which is primary care.

With respect to underserved and rural areas, the problems could go in the other direction if we are not careful and I think therefore one needs to establish special monitoring mechanisms to make sure we don't make certain problems worse. Although if we really had a true market test, I think a lot of our rural areas that have figured out a way to provide certain services for less money may turn out to offer a better value for dollar.

I think on the whole, we would be better served by having certain sectors, both inner city and rural areas, where we monitor to make sure that the system doesn't make a serious problem worse.

Chairman STARK. I would just ask both of you, Dr. Eisenberg and Dr. Altman, what in your personal opinions, not as representatives of your commissions, but one as a physician and one as a health economist, on the assumption that we need to control health care costs.

To accomplish that, do you think there is a need for a national budget or national budget system to accomplish that?

Dr. EISENBERG. Let me answer first. I do. I think implicitly we have a budget. We have a budget, but we haven't stayed within the budget and I think that is one of the major faults of the current system that we have no mechanism whereby we can stay inside our

budget. If we ask the various payers, they will tell us what they would like the budget to be.

Chairman STARK. You have no faith in a voluntary system?

Dr. EISENBERG. It hasn't worked. Expenditure limits and fee setting will help us stay within the budget. I think we need work force reform. We need better technology assessment and perhaps better control over the dissemination of technology, encouraging some, discouraging others.

I have faith that the guidelines that are offered to physicians will provide them with some better information about the way in which they can practice more effectively. But by themselves they will not work. Within that context of a number of interventions, I think that offering a budget and saying this is what we would like to spend now, we would like to know how you can live within that budget, makes a tremendous amount of sense.

I would have concerns about ways in which that can be implemented if the system is as disconnected as it is currently and whether or not that will inevitably mean that there will be providers who should be able to provide who won't be able to provide such as those in inner cities or at medical centers and whether there are individuals who should be able to purchase who won't be able to purchase because the budget has been exceeded and they will be left out.

We are concerned about Medicare. At present, Medicare rates are slipping behind private sector rates, down to 65 percent of what private insurance rates are. We are worried that access may be limited for individuals who have Medicare when part of the system has a budget and the rest of the health care system doesn't.

Mr. ALTMAN. I am more and more concerned about where we are heading without it. We have subsector budgets, Medicare being one, Medicaid being the other, and even within Medicare, physician and hospital inpatient being more limited than outpatient and home care, et cetera.

I think we are in serious need of repair both in terms of the balance of who pays what, and also what will our economy look like if this sector is pulling out 20 or even 25 percent of total income.

Now as I indicated in my discussion, I have been impressed by some of the market forces, but I think that some areas are way ahead of other areas. They are few and they are impressive and there are advantages to having the market do it. So I would be in favor of some overarching target and watching the different areas and seeing if they can do it without more stringent regulations. Ultimately I do believe we need to sort of look at ourselves in the mirror and say are we prepared to allow one sector of our economy to consume such a large percentage, and having a target is important.

Let me say one other thing. I am personally getting very concerned about the kind of glibness about \$400 billion is better than \$300 billion and \$600 billion in savings is better—it has become a kind of computer-generated game, Mr. Chairman, and I don't think that is helpful.

I think we have to recognize taking \$500 or \$300 billion out of one sector is quite a wrenching experience. So my—I don't know whether my old age is making me a little more moderate. I think we need to move forward on this, but I am concerned even in our

report that we let these numbers go out. I think we should get this system going. I don't think we ought to establish targets that we can't adhere to.

I think they are going to be disruptive. I think we ought to phase in. That is what other countries have done. They didn't just wake up one morning and say we are going to take a growth rate of 12 and make it 4. Every country that I have looked at increased spending before they reduced the rate of growth.

I am in favor, but we ought to do this in moderation over a longer period of time than thinking in 2 or 3 years we will zap off \$400 or \$500 billion.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Picking up on your last point, Stuart, I too am sorry you let these numbers out. CBO first studied what would happen, what would be the savings if we adopted the Canadian system, and they came up with \$67 billion. They recently testified that if you adopted that program, the total volume would increase so much that the increased health expenditures in America would go up 5 percent.

So letting one group of figures out without putting it in the context of the other effects is I think counterproductive in the current environment.

Let me give you a little example of why I think those figures are so troublesome and that is all by way of leading up to asking both you and Dr. Eisenberg to try to be a little more specific on this issue of how you would implement a global budget, because there no sense in talking about it if we don't know how to implement it.

Florida spent per capita three times what Wyoming spent on Medicare patients. Now ultimately from Washington we either give Florida three times per capita the expenditure allowance that we give Wyoming or we don't. And if we don't, the options that Florida Medicare recipients will have in terms of treatments, testing, procedures, I mean very concrete things, will be very significantly reduced. Correct me if I am wrong, but the way I read this situation is that Florida people are now getting that many more tests, that many more hospital visits, that many more procedures than people in Wyoming are getting.

There is at least a logical explanation as to why that is happening, but global budgets will force us to say to people in Florida in a rather arbitrary way that you are going to cut your volume very substantially so Wyoming can increase theirs. That is one problem.

That is why I want to hear you talk more about how you would allocate the budget from Washington and how you would deal with this kind of problem, because I can deal with this issue better in terms of practical examples than I can conceptually.

For example, if you allocate the budget by State on some sort of per capita basis, maybe you take into account age and poverty—at least you would have to take into account those two things—what happens if the incidence of AIDS skyrockets? Is New York City then going to pull resources from rural New York State or is the Congress going to come back with a supplementary appropriation making a farce of the concept of global budget and limits? Do we allocate to New York, Chicago and Los Angeles separately?

I appreciate your testimony. I particularly appreciate your caution and your recognition of the complexities of this, but if we are to really talk about a global budget, I really need to understand more clearly how far your thinking has gotten in the more technical matters of how do we actually decide what is the amount we are going to allocate? How are we going to allocate it? Who is going to have the power to enforce?

I think those things are in the end the nuts and bolts of whether this idea is practical and workable. I would like to hear you both pursue that a little bit.

Mr. ALTMAN. First, let me flip the coin and tell you why we provided the information, because we talked about this a lot. In some sense, information if inappropriately used, can be very dangerous. Let me flip it around. No information can also lead to a kind of a glibness which is even worse.

We tried to lay out examples particularly in the area of what you would have to do to go to some of these limits. As I was trying to say, you can say well, we are going to get the rate of growth to CPI or inflation. In these examples, we tried to show you what kind of volume reductions particularly for outpatient care you would need to generate, plus price reductions to get to there.

So you can take the numbers and turn them any way you want. You can say we will save \$500 billion or you can say "Gee, you are going to take \$500 billion out of the industry."

It was our job to provide you with the information. I trust you and the collective Congress and the administration to make appropriate use of it. That is why we included them, but we tried to include the caveat.

I hope we were not so flippant about the use of these numbers to imply that \$500 billion is better than \$300 billion.

Mrs. JOHNSON. On that particular point, it was helpful when CBO did a chart that showed the offset.

Mr. ALTMAN. We tried to show you what kind of volume reductions by sector you would need to reach those savings. We show that in the outpatient side you would have to either go to negative price increases or very substantial reductions in volume—

Mrs. JOHNSON. Did you articulate that also by State?

Mr. ALTMAN. No. I think your issues are very appropriate, but if we go back to the introduction of the Medicare DRG system, the Congress did something that if I would have predicted I would never have thought you would have done and gotten away with and in fact that we implemented it without a revolution and that is when we decided under Medicare to go to uniform DRG payments except for certain adjustments.

It took 3 or 4 years and we slowed spending growth and stopped it in most parts and it was jerky, but we did it. We also then made adjustments. If we are not going to be sensible about this, this can be a disaster.

I would hope if we had a serious AIDS epidemic or something new comes along and affects certain parts of our population, that the people responsible for allocating the budgets would take that into account just as we take into account sending special funds to flood areas.

If I looked at Florida versus Wyoming, for example, if you take in part A, Wyoming actually spends a greater percentage of—even though its Medicare rates are slightly lower—it uses part A more, 65 percent versus Florida, 51, where in Florida——

Mrs. JOHNSON. Is that chart in our materials?

Mr. ALTMAN. It is in our June report. We have tried to look at the State spending for Medicare by area, by part A, part B. We have combined them.

I think we are going to have to start from where we are, recognizing several things. First of all, if we do cover the uninsured upfront, the States that are now spending the lowest amounts will get the biggest positive shot.

I will provide you with this information.

[The information follows:]

Table 5-3. Hospital Payments by Source, by State Averages, 1991 (in Percent)

State	Payments as a Percentage of Costs			Uncompensated Care Losses as a Percentage of Total Costs
	Private Insurers	Medicare	Medicaid	
U.S. total	130%	88%	82%	4.8%
New York	107	95	89	3.5
Maryland	108	108	107	7.1
Rhode Island	108	99	91	3.3
New Jersey	111	98	119	8.9
Wyoming	111	86	94	3.1
Minnesota	114	92	84	1.9
Michigan	118	90	85	2.7
Massachusetts	120	94	89	5.8
Wisconsin	123	94	77	2.8
Arizona	124	94	80	4.0
Utah	124	87	88	3.5
North Dakota	124	88	96	2.2
Washington	124	100	82	3.3
Pennsylvania	126	90	74	2.7
Iowa	126	88	92	1.5
Oregon	126	96	65	5.3
District of Columbia	126	89	80	6.6
Ohio	128	87	90	4.0
Vermont	129	90	86	4.3
Kansas	130	88	82	3.5
Colorado	133	89	78	4.6
New Mexico	134	93	86	7.2
South Dakota	134	88	86	2.8
California	134	88	67	3.9
Montana	135	91	87	3.7
Maine	135	82	87	5.2
Indiana	136	85	99	4.8
Idaho	136	91	77	4.2
Missouri	137	87	77	5.3
Illinois	137	86	56	3.4
Nebraska	138	83	73	2.3
New Hampshire	138	83	90	5.8
Kentucky	138	90	99	4.9
Oklahoma	139	87	92	6.0
Texas	140	87	76	7.4
Connecticut	141	83	65	4.8
Virginia	142	90	73	6.2
Alabama	142	94	76	7.5
Georgia	142	87	88	7.5
West Virginia	142	90	85	7.3
Tennessee	143	87	82	6.1
Louisiana	144	87	87	3.8
North Carolina	145	89	85	5.8
Florida	146	84	82	7.7
Nevada	152	86	60	9.0
South Carolina	152	84	103	7.1
Mississippi	155	94	108	9.9
Arkansas	158	94	63	9.3

Note: In the first three columns, the payment received from each payer is shown as a percent of the cost of treating its patients.

Uncompensated care losses (net of operating subsidies from state and local governments) are shown as a percent of costs across all payers. Alaska, Delaware, and Hawaii omitted due to insufficient data being available.

SOURCE: ProPAC analysis of Annual Survey data from the American Hospital Association.

Mr. ALTMAN. If you take the uncompensated care losses and percentage total costs for hospitals, some States are very low, like Iowa, which is only at 1.5 percent uncompensated care loss; or Minnesota, which is 1.9. Others are quite high. Florida is at 9 percent. Mississippi is at 9.9. Arkansas is at 9.3. New Jersey is at 8.9. So we have significant differences in terms of the uninsured and they are getting or not getting care today. So I think there will be some equalization going on covering the uninsured. But after all that is said, there still will be differences and I think we should recognize upfront that those differences have been around for a long time and you can't dismiss them out of hand.

We have certain medical concentrations in this country. I live in Boston which prides itself on the quantity and quality of its medical care. People from all over the country and all over the world come there. I think we should recognize those differences.

Over time we may want to phase them up or down to adjust a little bit—

Mrs. JOHNSON. Your answer implies that you think what we would be doing here is allocating a global budget for Medicare, Medicaid and uncompensated care.

Mr. ALTMAN. No. You could talk about total expenditures. I am assuming—

Mrs. JOHNSON. My assumption is that the global budget concept applies to both public and private expenditures.

Mr. ALTMAN. That is right. If I led you in that direction, I am sorry. I was just talking about our attempts to more equalize spending within the Medicare program, particularly on the hospital side. I don't know how successful it has been on the physician side.

Mrs. JOHNSON. In terms of how you would identify the amount of per capita spending in the private and public sector nationwide and allocate it by State, did you give thought about what kind of formula would be necessary to do this in a way that would responsibly reflect the variation in medical costs from State to State?

I really don't even mean that in terms of practice costs, but in terms of frailty, age and poverty?

Mr. ALTMAN. We did not get into that level of detail. I in other parts of my life have tried to deal with that. I think one needs to recognize what is at the current time. We need to put together a database combining public and private spending on a per capita basis at least adjusted for age and cost of living at a minimum.

Mrs. JOHNSON. Can we do that in say 4 months, 6 months, a year?

Mr. ALTMAN. I think as you approach a year it becomes easier. I think 4 months would be pretty much impossible. There is a lot of information out there. It is a question of combining data sources.

We have a lot of information on Medicare spending. There is information on Medicaid and there is quite a bit of information now on private spending and data sources that we would need to marry up. We have tried to do that in some of the reports that we have given you.

So within a year, I think we could come up—and I don't know what the right time limit is, but it is not 10 years.

Mrs. JOHNSON. One last question on this line of questioning. Could we in a year also come up with a volume indicator that

would have to be attached to the global limit so that we would know that in adopting these limits or in allocating this money in this way to the States according to the spot formula, we would have to limit volume in such and such a way? I mention that because when we implemented RBRVSs because New England's cost of living is higher and Connecticut's cost of living is higher, our internists took a 20 percent cut. That had some consequences and we did not anticipate it would be that deep.

I think we need to have a better understanding of what is going to be the impact than we have had in some instances.

Dr. Eisenberg, while I don't have time to ask this question now, I would at some point like you to talk about this subject in the context of our need to have phased in the RBRVSs and your recent statement that we need to be very cautious about not phasing in practice cost differentials until we complete the process that we are currently involved in. I thought that was an interesting statement that you made recently.

Mr. ALTMAN. Let me turn this over to John because I think the PPRC has had a lot more experience in volume offsets and reductions than we have.

Dr. EISENBERG. Much of your concern obviously has to do with interstate differences and the impact if an expenditure limit is based upon a State as the boundary for that expenditure limit. I would try to respond to that and add to the second part of your question.

Our recommendations have always been that a transition should be used in order both to gather data about the impact of the policy change as well as to enable both beneficiaries and physicians to adjust to the change so that there isn't an overly rapid change.

Our recommendation with regard to practice costs are similar to that. Our recommendations with regard to expenditure limits would be the same, that we would use the historical baseline, that we would have a goal of reaching some figures that are closer to equity across States or whatever we deemed to be closer to equity, but that wouldn't happen suddenly, that we would probably use some uniform update initially and then change the updates over time as we understood better why the differences across States existed.

Maybe it is due to cost of living. Maybe it is due to inappropriate services, and we need to look into that. I think your point about being concerned about the differences across States is consistent with our concern about the States, but also our concern about having too many categories of services for which a limit is based. The smaller the sample size, obviously, the more variation there will be.

There are large variations from year-to-year in which State is at the top or bottom of the list. Because Wyoming and Florida have a threefold difference 1 year of course doesn't necessarily mean that they will another year. One of the solutions that we might want to think about is having a rolling average of expenditures so that you don't use just the last year's expenditures, but you might use some average that would eliminate some of those year-to-year variations that would cause dislocations in the fee structure going up and down wildly from year-to-year.

Another issue that we will need to be looking into and you will as well I am sure is the way in which the data are collected. Presently some of the data collected are reported on the basis of where the services are delivered and other data are based upon where the beneficiary lives.

We could misinterpret the way in which we think there are interstate differences in the delivery of services unless we understand that. For example, in the District of Columbia, 31 percent of hospitalizations occur for people who live outside the District and that skews the way in which it looks as if per capita expenditures are being calculated.

So there are a number of technical issues like that—the transition, the gradual change toward something closer to actually looking at the reasons, being sure that we have a rolling average—that we think would help us design an expenditure limit but still within the caveat that the more subdivisions that we make, the harder it is going to be to have those expenditure limits.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me thank you both for your testimonys today. Your points I think we would agree with, first that global budgeting without other reforms would be something we don't want to move forward with. We need to incorporate other reforms as we move ahead with the budgeting issues. But I also appreciate your suggestions that we move ahead.

We are not going to get answers without making decisions and we are going to have to work out some of the problems after implementing legislation is brought forward.

I also appreciate your personal views that to achieve the cost saving we will need some form of budgeting in national reform. I have a strong preference on the budgeting and that is that the budgeting, although it be national, it be allocated to the States and that the States enforce the budgets within their own particular States.

My views have been reinforced by much of what you have said here today. I would like to concentrate on some issues that have not been fleshed out yet as to the advantages or disadvantages of using local enforcement of budgeting as it relates to those particular issues.

Stuart, you mentioned complexity. Surely the United States health care system is very complex, and as we go into a transition to a new system, there is going to be a lot of complexity as we try to implement budgets. It seems to me we have a better chance of being able to sort out the problems by having enforcement of the budget done at the local level rather than at the national level, that unique problems of various regions of the country are better handled at a State level than at the Federal level.

On the issue of dealing with the differences among the States, we don't know all the explanations as to why some States seem to be spending a great deal more per capita than other States, but we know that there are problems and that we need to deal with those problems in some form of a transitional way. My concern of looking at national budgeting is that we have had a national system in

Medicare and it has not brought about equality among the various States. Are we capable at the national level of developing a global budget that will deal with the differences that have occurred in our system where some States are spending so much more or have so much higher utilization than other States? We would have a much better system or much better equality if we developed a national formula for allocation to the States and then put the States responsible for achieving those targets.

When you are closer to the people, where the dollars that are to be given out are closer to the services that are being rendered, there is a better chance of reaching the desired results. I think there are.

I would welcome your comments as to whether you think a national system can achieve the equality or whether we have a better chance of using the local budgetary systems to achieve equality among the States?

Mr. ALTMAN. I share your support for bringing the decisions closer to the local areas, although the definition of local is up for grabs. Some local areas have more concerns with their State than they do with Washington. I think we are dealing with health care regions, sometimes cutting across State boundaries.

I would like to focus on what Canada did. This is my personal point of view. It is an interesting example of how the Federal Government in Canada balanced its controlling mechanisms with the provinces. They used to have a national system there where the Federal Government just paid a percentage of the total and some time around the late 1970s, the Federal Government said "Look, we have budget restrictions on us and we are going to allocate money across the board on some formula to each province, but each province is going to be responsible for controlling their own expenditures."

To the extent that provinces choose to control it differently, they have to come up with the money themselves. We at the Federal level are going to insure that you provide basic services and we will provide our share of those, but if one province wants to provide more they have to come up with the internal funds and not have it sort of redistributed all across Canada.

It is possible that we may eventually move in that direction ourselves. I think it would be a big mistake to put every area of this country into the same cookie cutter. So it is possible that we say to a State, we are a country, and we have certain responsibilities that cut across all States and we at the Federal Government are going to give our share to do that, but if you as a State feel that health care is so important or it is a big industry and you want to spend more, you will have to come up with the money either to have higher premiums on insurance in that State or higher State expenditures.

Mr. CARDIN. Couldn't the system also permit States to use different methods for achieving those goals? One may want to use rate setting. The other one might want to use budgeting or another State might want to use the premium-based controls. There would be no need to have the same system in every State?

Mr. ALTMAN. Absolutely. We have to have strong national goals. We have learned from the Medicaid experience that when we are

too weak on that, we really come up with solutions in some parts of the country that some people have trouble with. So I think we need national targets if not restrictions on what is acceptable and what is not.

People talk about there being only one way to go. There isn't one way to go. Nobody knows. There isn't a better solution. Some solutions are better for certain things than others.

I have always felt that we gain by having these kinds of differences across States. To the extent it makes it more palatable politically and gives us more information over time, I think we are better served by that, I personally feel, to allow, within overarching Federal rules and guidelines, States to have flexibility on how they met their targets.

Dr. EISENBERG. Let me add, PPRC recognizes many of the political and governance advantages of allowing States to take responsibility for expenditure limits. States have budgets, for example. Of course, if a State's physicians and hospitals were to overspend their budget then the State might have to pay that amount rather than it being a responsibility of the Federal Government and that is an advantage from a Federal point of view.

Mr. CARDIN. The rolling averages that we have talked about takes care of unpredictable changes?

Dr. EISENBERG. That is right. The Commission has met and talked about relative advantages of State delineation of the expenditure limit or of health reform. It doesn't have a position, but we see advantages and disadvantages on both sides. We are worried about what has happened to the single program we do have which is run by the States which is Medicaid.

We see the differences across States and the differences in expenditures that have evolved because of the State's capacity to operate or to finance that system, but we do recognize the political advantages of the State boundaries.

There are three other issues that I want to point out that we as a Commission have talked about and that I think are important having to do with whether or not the geopolitical boundaries coincide with the boundaries of medical practice. In many cases they do. In many cases they don't.

Stuart alluded to the fact that medical practice is often regional not organized along geopolitical boundaries, so we thought without saying that one or another is better, what if we had a model like the Port Authority model which is defined along the line of a commercial area or region as opposed to simpler geopolitical boundaries. That might make more sense given the way that health care is delivered.

Mr. CARDIN. We are not suggesting by having local enforcement of budgets that there wouldn't be strong guidelines by the national government on health care policy as to what would be the mandate on programs, et cetera, which would be stronger than what we are doing in the Medicaid program. There is also, of course, the suggestion that there would be some fallback to some form of national enforcement if a State were not prepared.

If they were not able to bring in the targets, there would be some fallback to a national enforcement arm to make sure that we do achieve the budgets over a rolling average period of time to deal

with the unpredictable changes. I think that is a better way to deal with many of the problems that you suggest could be handled and yet you have the diversity and the experimentation and with the whole concept that the United States was about.

Dr. EISENBERG. I agree. There will be some instances in which a State might want to have a multi-State or even a national system established with the development of guidelines or the evaluation of the effectiveness of medical care. You wouldn't want that to be done in each State, I would assume.

We know that the professional medical societies tend to be organized both at the State level and across specialties at the national level so there are going to be a couple of ways of cutting that as well.

Finally, the more we learn about at least on the physician side ways of influencing physician practice, the more we realize that the sub-State level is the most important, the group of physicians who practice together or the hospital medical staff who influence one another. So whether the budgeting is done at the State level or not, I hope that we could look broadly at the way in which physicians' practice is influenced and the way in which patients come in to physicians from across State boundaries and be sure that we take that into consideration.

Mr. CARDIN. I want to call to your attention to some of the data collection that is being done locally. The Maryland legislature passed a law this session that will do a good deal of the data collection. You might find that we do have a State model looking at ways of developing material necessary to implement the type of systems we have been talking about. You might want to look at that.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman.

I want to thank you both for coming and sharing your ideas. We have bounced back and forth between global and specific issues. I want to go back to the global issue.

We are sitting in the middle of a reconciliation process in which we are talking about cutting \$50, \$60, \$70 billion out of the Medicare budget. One of my concerns is the whole question of how much everyone needs to be in the system at the beginning or is it possible to phase in bringing in of some portion of those uninsured and gradually folding in Medicare 3, 4 or 5 years down the road? Can we allow the system to remain fragmented and get an effective cost containment with global budgeting?

We can give the States x number of dollars but if we allow these systems to continue to operate independently, what is your estimate of the impact of that on the ability to get the cost containment out of the global budget?

Dr. EISENBERG. PPRC has not taken a position. I personally think that an expenditure limit will not work if there are multiple components of the system that aren't coordinated.

It is the old story about squeezing the health care cost balloon. It will pop out somewhere else. So we have to look at the whole package.

Does that mean every component of the health care system has to be included in the package on day one? I would say not nec-

essarily as long as there is a plan to move them in over a short period of time, a few years.

Mr. McDERMOTT. A few years being defined as—

Dr. EISENBERG. Three or four. I think the fact is that if our experience with the Medicare volume performance standard is an example, the current databases we have will give us feedback that is delayed by a period of time which may be as much as 12 to 18 months anyway and the responsiveness of the physicians and the hospitals will be to some extent delayed based upon that data as well.

If you are looking at the behavioral response to an expenditure limit, we aren't talking about a few months anyhow. We are talking about a few years so I think we have a few years to deal with a logical and careful transition to the full system.

Dr. ALTMAN. I think we need to separate out phasing in with global budgets. I would be opposed to introducing a global budget, a tough global budget without everybody being in the system. So if you wanted to phase in the uninsured for example over 4 or 5 years I would hold off the introduction of a global budget until you had the whole system in place. That doesn't mean you necessarily would hold off any form of cost containment.

You may want to introduce some kind of structural limits on rates of growth short of a global budget while you are phasing in the uninsured or you may say "Look, we have accepted the reality of our spending up to now. Let's let it continue to grow while we phase in the uninsured, and when we get everyone in and we have an organized system there, then you can introduce the global budget."

I fear cost savings first and bringing on the uninsured second. The reason why I fear it is I think not only the uninsured but also the Medicare and Medicaid populations become very vulnerable in a situation where providers are going to have restricted budgets. This cost shifting environment as it has been called is very real out there and it has allowed those of us in Washington who are responsible for Medicare and indirectly Medicaid to essentially have a bit of a free ride because—

Mr. McDERMOTT. As a former State legislator, I know we had a free ride. We used to use it all the time.

Mr. ALTMAN. It has become an art form. If you freeze that or restrict it and say providers cannot shift the cost, as a matter of fact you have to cut it back because you face the global budget and you then restrict Medicare payments or continue to have the uninsured, the implications for the uninsured can be very substantial.

Phasing in sounds OK, but I wouldn't phase in a global budget.

Mr. McDERMOTT. Let me just try and paraphrase. What you are saying is that if a global budget is going to work, there has to be a significant investment upfront to bring everybody into the system in one form or another at the very beginning?

Is that fair to characterize your testimony?

Mr. ALTMAN. Yes. Unless you are prepared to pay the consequences the other way.

Mr. McDERMOTT. That is a built-in two- or three- or four-tiered system?

Mr. ALTMAN. Or no tier. There is a lot of good health care being provided to people that are uninsured. You go to hospitals, sick people wind up on their doorstep and get a lot of care for nothing, and then turn around and charge other people. If all of a sudden they can't charge those other people, I don't know what they are going to do, but there is a possibility those other people won't get the care.

Mr. MCDERMOTT. Dr. Eisenberg, does that make sense from a physician side that you have to have everybody in from the beginning?

Dr. EISENBERG. With Medicare effectively using expenditure limits through the MVPS, we have looked at whether or not there has been any decrease in access. It has been surprising that so far, although the Medicare rates are substantially below the private rates, there does not seem to be evidence that access has been limited.

Over 95 percent of physicians say that they are still taking new Medicare patients. The problem with that is that the anecdotal information that we get flies in the face of the hard data that we are getting. I suspect that what is happening is that there is a window during which there won't be a major decrease in access to care, but that if the fees become too disparate or if the limitations become too disparate, I think you are right; Stuart is right, that there would be a limit in access to care.

But I do think there is a window for implementation and that is the reason I suggested that we might have a short period of a phase-in before any adverse effects would occur.

Mr. MCDERMOTT. Both of you have talked about the GDP. One of you, Dr. Altman, suggest using GDP would be highly disruptive.

Dr. Eisenberg, you suggest that this is a reasonable or good way to go as a target. Maybe there is a nuance there between the two of you. I would like to hear you talk about why one thinks it would be highly disruptive and the other thinks it would be a good way to go.

Mr. ALTMAN. If you turn to figure one in my testimony and you look at annual changes in facility-based health spending and gross domestic product, and you can find any relationship to the two, you are better than I am. I am saying that I think a target of average GDP growth over a 5 or 10 year period makes sense, but not annual GDP growth.

Mr. MCDERMOTT. You are talking about the rolling average and trying to smooth out the—

Mr. ALTMAN. Right. If you look at figure 2, the trends between health care spending and inflation plus population are a lot better, but the gap is wider. So either some rolling average of GDP or using GDP as the overarching target and then allowing inflation plus population to be your annual adjustment—some mechanism—but don't simply tie annual expenditures of health care to annual changes in GDP.

I think that is very disruptive.

Dr. EISENBERG. Our point was similar and our figure is even similar. It is figure 1 on page 4 of the report. We feel that the GDP is a target, a benchmark. We wouldn't suggest that we be religious in our sticking to exactly what the GDP was, but there are a few

variations. One is the rolling average point and another is that there may be decisions made by the Congress to increase benefits, to increase coverage that would justify an increase of the GDP, but that the GDP is a reasonable benchmark to use as a rolling average for increase in expenditures.

Mr. McDERMOTT. I would like to ask the question of both of you. A system that would come in tomorrow and would reduce increases in health spending immediately to GDP would be unworkable. We know that. The question is how you put a net around the whole system and how quickly you draw it in to some position that you would ultimately like to get to.

The question that I have is what makes sense to you in terms of historical expenditures? If you put a global budget out for the State of Florida and one for Wyoming and you say, "The global budget that we are allocating you is x and we will allow you next year to have GDP plus 5 percent, 6 percent," If they are increasing at 15 percent a year or 20 percent, how quickly do you see that being brought down in any kind of reasonable way without data—although we didn't worry about data with DRG's.

Dr. EISENBERG. The PPRC has suggested that we shoot for the year 1997 as the year when we would reach the GDP growth rate for the Medicare physician payment. That is the only thing that we have been dealing with so far, but we felt that at least from what we have responsibility for at the present time that that was a reasonable number of years over which that transition could occur.

Mr. McDERMOTT. Presently GDP plus what in physician rates?

Dr. EISENBERG. It is 3—our current rate I believe is 8.1 percent. I would have to look that up. My recollection is 3 percent above GDP growth.

[The information follows:]

With its recommendations for the 1991 Volume Performance Standards, the commission set forth a long-term goal of reducing the rate of growth in Medical physician expenditures to the rate of growth in GDP (adjusted for growth in the Medicare enrollee population) by 1996. Because growth in volume of physicians' services had typically exceeded GDP growth by 4 to 5 percentage points, the commission recommended a strategy of gradually reducing the VPS by 4 to 5 percentage points below the expenditure growth baseline.

In order to reach this goal, this commission recommended an overall VPS for 1994 of 11 percent, which is 3.5 percentage points below the Medicare actuary's projected 1994 expenditure growth baseline. Such a standard would make full allowance for growth and aging of the beneficiary population, the effects of prior legislation, and changes in payment rates. If the Congress should enact fee updates less than the full default formula amount, there would be a lower projected and thus a lower VPS.

Mr. McDERMOTT. So you are talking about 4 years to come down 3 percent?

Mr. GINSBURG. On the Medicare volume performance for physicians, I think we are about 1 percentage point above the GDP growth rate in setting the performance standard for 1994. It started 3 years ago, so it has been about a 5-year movement. The total reduction will be about 4 to 5 percentage points.

Dr. EISENBERG. Remember that Medicare rates for physicians have increased more slowly than overall increases for physicians so there is going to be some difference between what we do in Medicare and what we do overall.

Mr. McDERMOTT. If we were setting a national global budget, we couldn't use Medicare as the standard, but we would have to use something higher?

Dr. EISENBERG. Exactly. We would have to use the historical baseline for whatever services we were talking about.

Mr. McDERMOTT. How about in hospitals?

Mr. ALTMAN. Let me make a statement that we have no technical idea what is a good number. The real answer to your question is I haven't got the foggiest idea.

Mr. McDERMOTT. But you know that we make decisions without the foggiest idea, right?

Mr. ALTMAN. If you ask me am I prepared to make a decision, sure. If you ask me professionally is there some formula that is the right number, 3 years, 5 years, no.

The second is GDP. You may want to go to GDP plus. GDP plus would allow this sector to grow a little bit relative to others. Maybe given our high income that is not inappropriate.

In economics, we talk about positive goods, and health care is a positive good meaning you spend more for it to the extent that you are wealthier. If you decided to go GDP plus 1 or 3 percent, health care is growing 4 percent on average faster than GDP. If you cut that in half, you would be doing something. You ought not be fixated on GDP as the number. It could be a little beyond that.

We modeled it over a 5-year period. There is nothing magical about that. Five years is easier than three and harder than seven. We have no country, no country has ever tried to do this. So we are outside—because they started from much slower growth rates. The one country that is impressive on what they were able to do is the Germans.

When you look at how the German system was growing in the late 1970s and how they managed to get it down. Other than that, other countries just took where they were and slowly slowed the growth.

Mr. McDERMOTT. Thank you, Mr. Chairman. Thank you both.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Gentlemen, returning to the original mission that the chairman assigned you in December which was to study the issues involved in the design and the implementation of a national health care budget plan, we have talked about the Federal Government's responsibility for expenditure limits and Mr. Cardin brought up the State, possibly even local, entities of government's responsibility.

Let me take your assignment one step further, and this is probably not in your report, but what about the individual consumer, the smallest unit of consumption, and his or her responsibility for expenditure limits that might be imposed and specifically to what extent would a tax cap on the deductibility of health care expenses be an effective mechanism for cost containment in a grand design for reducing health care costs?

Mr. ALTMAN. I think it is a positive addition to the extent that individuals face the financial implications within reason of spending more money. I think we have made much too much of it. I hate to say this. The idea that it alone could be the mechanism to sort of bring about the discipline is—it just flies in the face of the arith-

metic let alone the realities of it, because what you are dealing with is a marginal tax rate on top of a percentage of the premium that would have to be paid. When you look at that in comparison to the total, it is quite small.

So my answer is, it is a positive addition to a set of techniques used to constrain costs, but I don't think that alone it could be very effective.

Dr. EISENBERG. I think there are two ways in which it could help the individual. First, if expenditures grow at a slower rate, insurance becomes more affordable, more individuals are able to obtain insurance through whatever mechanism, through health reform or through current systems. That I think would be an advantage to the individual who may currently not be able to get coverage or adequate coverage for insurance.

The second has to do with the policy decision that you would have to make. If there is an expenditure limit what is counted as part of the expenditures that are limited?

One option would be to include the benefits that are mandated in a Federal system. If we have a package of benefits that are required of providers, then those might be included, all these benefits might be included and anything that is outside of that package might not be included, cosmetic surgery, for example, over-the-counter drugs. So that the protection is going to be limited to some extent by what you decide to include within the budget.

Another alternative would be to consider any services that are purchased with insurance that has a tax subsidy, that would broaden the definition. That will leave the decision to you to some extent.

Mr. GRANDY. Let me pursue the first option because it was outlined by an editorial in The Washington Post that talked about—and I don't know if he meant by denominating the value or merely designating a standard benefit package which would be the amount of the allowable deduction—is this an effective way to basically contain growth, or as Dr. Altman suggests, do you also have to put a global budget on top of that as well?

In other words, if you have a standard benefit package which supposedly is going to be uniformly offered to all Americans and that is the level of tax forgiveness that the code will permit, do you then have to have an aggregate global budget sitting on top of all of the health care expenditures as well?

Dr. EISENBERG. Let me respond.

First, the Commission as you might imagine has not dealt with that issue.

Mr. GRANDY. I know. I am asking you as individuals.

Dr. EISENBERG. One thing that we generally conclude in the Commission is that there is no magic bullet and no single solution will solve this problem. My personal opinion is that even with a tax cap that a global budget would be necessary. I don't think that the tax cap will necessarily influence the increase in expenditures sufficiently and believe that a global budget or expenditure limit would help us get to that target more quickly.

Mr. GRANDY. I guess my reason for pursuing this line of questioning is I have no doubt that we can create a global operating budget, but I am less convinced that we can enforce it, and I base

that on the annual budget exercise that we have in this Congress every year which is exacerbated right now by a huge disaster in the Midwest which will involve a supplemental appropriation, which we will pass and I dare say it will be roughly twice the value that is speculated in the press because there are usually things added on under the guise of emergency spending.

My concern is if you leave that in place and expand it to accommodate health care cost containment, a lot of the same mischief is going to take place there unless you also put some kind of burden of proof on the consumer as well, either by limiting the amount of revenue foregone through tax forgiveness or by denominating a benefits package and saying "Above this, you pay for it with after-tax dollars."

I have only been here for 7 years, but I am on my third 5-year budget deal. So I am a little suspect about creating a new scheme just for health care.

There will be disasters, whether it is an AIDS epidemic or whether there is an increase in health care driven by poverty or welfare or whatever. I am afraid that unless we do something to the smallest unit of consumption to put the burden of proof on them, we can create any design we want, but we will never really force the kind of sequestration that you would have to have to make it work. That is politics.

Mr. ALTMAN. I don't want to comment on that because you understand the politics better than I do. I do want to comment though on the expectations that simply reducing or eliminating the tax deductibility beyond a certain amount would—what possible impact that could have.

Think of it as a coinsurance rate. We have had this big debate on should we have a coinsurance rate. I have always supported coinsurance as a legitimate part of some kind of a cost responsibility on the part of the patient.

Does it have an impact? I think most studies say yes, it has some impact. Is it strong enough alone to substantially reduce the rate of growth? No. We talk about a 20 percent coinsurance rate. For lots of people they are in a 15 or 28 percent marginal tax bracket and we are only talking about the rate of increase say above an expenditure, which probably is going to average around 5 to 10 percent.

Is 5 to 10 percent enough of a force to slow this engine? What possible evidence do we have to say that it will? So should it be part of a plan, yes. Is it alone enough to slow this? No.

If you are prepared to buy what it will give you, fine. We will go, maybe rather than 20 percent, we will go to 19 percent. If you believe that collectively that is OK for this country, then that is where we are going to go. We are probably going to go there any way.

The issue is whether this relatively painless solution—I don't disagree with the comment about the global budget, but this relatively painless solution, because it won't be as painful as some of the others—will have the desired impact. It is hard to really justify it alone as an effective force.

Dr. EISENBERG. Asking for more consumer responsibility certainly makes sense and I suspect in the long run would help to re-

duce some of the demand for medical care. The concern is that there is a substantial amount of evidence that that is indiscriminate reduction in services, that some necessary and some unnecessary services are reduced.

I would hope that in designing a plan that we could try to be sure that those incentives to put responsibility in the consumer or the patient's person are going to be designed in a way that would eliminate the possibility or at least reduce the possibility that they would not get the preventive services or the initial services that they would need.

Mr. GRANDY. That is why I specifically talked about a value either denominated or specified benefit by benefit for a plan as opposed to a Medisave account which would essentially be a medical IRA which could be cashed in or out.

Obviously there is disagreement on this panel as to whether or not that is a viable mechanism of cost containment. I am one who personally believes that you can't just give somebody cash and say "Go out and buy your health care," and you will become a prudent consumer. I do agree with you on that.

Gentlemen, thank you. Your testimony has been very helpful.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Like the chairman and my colleagues I want to thank you for being here this morning, for your report, for your testimony. You have made a real contribution, a contribution that is really needed now more than ever before as we move down a road that we haven't traveled before.

This Congress must act and I am of the opinion that we must act right now. There is an old saying that the time is always right to do right. The American people are demanding that we have national comprehensive health care.

Mr. Altman, assuming that we have a national budget. How should it be allocated among different types of services?

Mr. ALTMAN. We didn't get into this. We did play out hypotheticals. I personally think it would be a mistake to divvy up the budget by sector. I think you are better served by having limits on per capita spending and allowing plans and individuals to choose among the services that are available, because we do things very differently today than we did 10 years ago in terms of where we get our care and what kind of care we get. So I don't think it is a good idea to sort of pick one service over another.

Dr. EISENBERG. Our position has been that we ought to have as few different categories as possible. There is a substantial amount of substitution across certain categories of care. We know that people who used to be taken care of in the hospital are now in the outpatient department or in a doctor's office.

Even within a certain kind of disease, say gallbladder, we know that what might have been a major operation 5 years ago is either now a minor operation or no operation at all and treated medically. If we know that these substitutions are going to occur in the future—and we do—then we would like to see a plan designed so that as much as possible the substitution occurs within category rather than across categories and the more categories you have the harder that will be to do.

Mr. LEWIS. Could you elaborate on how you enforce a national budget?

Dr. EISENBERG. There are two basic ways. One, by rate setting and the other is by premium limits. They could exist side by side. Imagine that we have established an expenditure limit or a target for a certain period of time. We have a 2 or 3 year rolling average expenditure and we see whether or not we are within that limitation.

There would then need to be some mechanism for establishing what the maximum fee would be for certain services. It could be along the lines of CPT codes, for example, for physician services. If the expenditures were greater than the limit or the target, then that increase would be lower than it otherwise would have been much like the Medicare volume performance standards.

Our experience with the Medicare volume performance standard during the past year suggests to us that the system would work because the rate of increase was lower than expected to be or lower than the Congress had set the rate to be and the update is going to be larger than it otherwise would have been so that the fee then becomes adjusted in a way reflective of how much the volume changed.

If you are dealing with a managed care organization, you might use the same calculus to determine the premium and you could establish a limit on the premiums to be charged by the HMO or the managed care organization. So basically when all is said and done, it boils down to the simple formula that volume times price equals total expenditures. If one goes up and you are going to stay within a budget, the other has to go down.

Mr. LEWIS. Is there a particular plan that would fit better under this umbrella of a national budget-managed competition versus single payer?

Dr. EISENBERG. I think an expenditure limit could be used with either model. As we have looked at the large number of proposals that have come from the Congress, some of which are evaluated in our report, almost all of them could use a form of the expenditure limit. They could devolve it to the State so that the State has a budget and the State could decide how to use the money.

You could devolve the expenditure limit to a managed care organization or to alliances, for example. You could use it with a single payer system effectively and expanded Medicare. I think it is applicable to almost any of the options.

Mr. ALTMAN. Although I would qualify, I think trying to put in premium limitations in a kind of disorganized and nonfunctioning kind of a market that we have today would be extremely difficult. You need to organize the market better a la what is called managed competition I think to make a premium control system work better. A single payer system lends itself better to ratesetting budget controls. It is easier to deal with.

It is not that it is not possible to have rate setting and budget controls in a nonsingle payer—it is harder because you have a lot more actors to worry about—so I agree that you can do any of them with either of the two but it is easier to do a premium control with organized markets and it is easier to do rate setting or budgeting controls in a single payer system.

Mr. LEWIS. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. You have looked a lot at other countries. We have had very limited experience with global budget and price setting because it has been narrowly focused on one sector and therefore there is the cost shifting problem, et cetera.

In looking at other countries, roughly how long have other countries used global budgets? How many of the countries that use them have included physician payments in their global budgets? For instance, France doesn't. That means what you are controlling is very different than what we are talking about controlling.

Are any of the countries that have global budgets looking for more precise instruments of control and I would say more rational instruments of control and is there any difference between countries that include physician reimbursements and exclude physician reimbursements and your other comments on looking at and studying the use of global budgets in other countries in terms of its implications for our experience?

Mr. ALTMAN. Germany and Canada, the Netherlands, England, all have different forms of expenditure limits that include both hospital care and physician care. But I think your main point is correct. The hospital sector of most of these countries has always been under stricter budgetary controls than the physician side. It has only been relatively recently that Canada, and it is only in some provinces, has tried to limit total expenditures.

Many have had fee limits, but they have not controlled volume. John can talk more about the physician side, but on the hospital side, all of these countries, including France, have had fairly strict limits on the rate of growth of their hospital sector with budget authority and it is usually a budgeted system as opposed to a rate setting and they don't think in terms of premium limits.

So it has been a long process for them and now it is just a question of bringing the physician underneath that and the physician side is much more difficult because you have so many more individual transactions and individuals who are practicing.

Finally, your question about are any of the countries that I have looked at or we have looked at happy with their system? I think the answer has to be no. They are all trying to make their systems better.

Germany has just embarked on a fairly substantial change in its system. The Canadian provinces—all are moving to make them tighter. What is interesting is we are 14 percent and they are at 9 percent, but if you listen to their rhetoric, their 9 percent sounds like our 14 percent. They are not very happy with where they are either.

So everyone is looking to make it better and they are looking to us on two levels: First, the DRG system is becoming more common around the world; and two, they are looking at markets trying to create markets. So they are going in both directions.

You can't say the Netherlands is trying to introduce a market, Canada worries about how do we bring in HMOs. So they are constantly searching for new ways. England, too.

Mr. McDERMOTT. Would the gentlewoman yield?

How do the hospitals in these other countries control their capital expenditures?

Mr. ALTMAN. That is a good question. Most countries deal with capital in two ways. The small capital items are often included in their operating budgets and they have a limited amount of flexibility each year for buying small equipment.

Big capital projects, new hospitals—

Mr. McDERMOTT. What dollar amount—how do they define big?

Mr. ALTMAN. My sense is that most of these countries allow a couple of percent for the hospital to spend as they wish and therefore big is defined more in terms of their own internal needs, but they have limits.

I was just talking to someone who is involved in bone marrow transplants looking at different countries, and he was saying how there is a difference between Canada and Germany and the Germans are more restrictive. The small items as a percentage of their budgets are included in the operating budget, but the big items come in a separate allocation.

In all countries that I know, of capital is allocated separately.

Mr. McDERMOTT. Is there a certificate of needs process?

Mr. ALTMAN. Something akin to that.

Mr. McDERMOTT. Nationally?

Mr. ALTMAN. No. In Germany it is by their States. In Canada it is by their provinces and even by their subprovinces. When you get to small countries like the Netherlands and others, they may be more national.

Dr. EISENBERG. From a physician side, there are interesting lessons from other countries. There is no system we believe we ought to adopt, but there are some interesting messages. One message is that there aren't very many countries that have an explicit global budget, but there are a number of countries that act as if they do.

For example, in Japan, there is an annual updating of the fees that physicians are provided within the context of what the total growth in expenditures are and the government has a certain amount that it is willing to have the overall increase in fees be, but it is not an explicit global budget per se.

Mrs. JOHNSON. By that, do you mean they don't have a volume control?

Dr. EISENBERG. There is an implicit volume control because the government, the Ministry of Health and Welfare looks at the total expenditures that they have had and then decides how much they want the increase to be in the next year, working in conjunction with the Diet. So they don't prospectively say "Here is your target, and this is what we want you to try to achieve."

It is basically looking retrospectively much as we did in the late 1980s as we went through an Omnibus Budget Reconciliation Act each year and said, "Well, expenditures were such and such last year so now let's change physician fees, to increase by a certain amount. I think from our perspective, a prospective system which signals to physicians how much the increase is going to be takes the advantage of the fee setting that the Japanese have plus a signal to the physician ahead of time that there is the possibility that your fees will go up higher if volume is controlled.

We don't know if that is the reason why we enjoyed a decrease in Medicare expenditures during the past year, but we would like to think that at least we are starting to see some responsiveness to the MVPS. So there is that lesson from the other countries, that fee setting is governed to some extent by an implicit global budget even though it is not as explicit as what we have been discussing.

A second is that in most countries that we are discussing they don't have as many different payers as we have, so that in some ways an expenditure limit or global budget is easier to implement. A fee structure is easier to implement when there are fewer payers than we have in this country. In Japan they have multiple payers, but a fee structure that applies to all those payers, so they are able to regulate fees in that mechanism.

Third, if we look at Germany we see with the most recent reforms the inclusion of services other than those that the physicians provide as a part of the expenditure limit. Pharmaceuticals are now part of what physicians are judged on when you determine whether the increase in expenditures for which physicians were responsible was high or low. We have commented on the fact that we might consider that in this country. We might want to look at things other than just the 18 to 20 percent of health care that is for physician fees, but also look at all services which physicians provide or which they prescribe.

Mrs. JOHNSON. Thank you.

Chairman STARK. Dr. McDermott.

Mr. McDERMOTT. You talked about one of the things that I have wondered about and I don't know the answer to this. In Canada, if you come down from Toronto to Buffalo or you go to Edmonton and you get sick, how are your bills paid by the Ontario health care plan—both hospital and doctor?

How does the Canadian citizen get reimbursement for medical services delivered in the United States?

Dr. EISENBERG. My assumption is that they don't cover those services unless it is an emergency, but we can certainly find that out for you.

[The information follows:]

In general, physicians are paid on their usual fee schedules when they treat patients from another province. For example, when a British Columbia patient obtains services in Ontario, the Ontario physician is paid by the British Columbia provincial health plan based on the Ontario fee schedule. Reciprocal billing agreements to support this policy exist between all the provinces except for Quebec.

In the case of Quebec, the provincial health plan will pay the Ontario physician, for example, only the amount provided in the Quebec fee schedule, which is generally lower than that in Ontario and most other provinces. The Ontario physician may bill the patient for the difference between what he or she receives from Quebec and the fee allowed in Ontario, although it may be difficult to compel the patient to pay this additional amount. Although Canadian law prohibits extra billing by physicians, this extra billing is permitted.

The situation is different when Canadians receive services from physicians in the United States. In some cases, the provincial health plan may arrange for certain services to be furnished by U.S. physicians. In such a case, the provincial plan pays physicians either based on the normal provincial fee schedule or at a rate agreed on in a negotiated arrangement.

Where the decision to seek services from U.S. physicians was made by the patient, either in an emergency or a discretionary situation, the patient pays for the services out of pocket. Canadian citizens traveling in other countries on vacation are typically advised to purchase private insurance to cover such situations.

Mr. McDERMOTT. I think Canadians spend 4 percent of their budget in the United States.

Mr. ALTMAN. Let's separate out two things. Sometimes the Canadian provinces send their people to the United States and pay for it.

Mr. McDERMOTT. That is under contracts?

Mr. ALTMAN. Yes. Those contracts are sometimes lower than what Americans pay for the same service, but much higher than what the Canadians pay for it if they did it in Canada.

Usually in high-tech areas where the provincial government hasn't sort of brought its capacity up to a level that it wants—open heart surgery is a good example, but the second is the relative issue of an emergency versus an elective. Clearly if it is elective, the individual pays for it.

There are a number of Canadians who bounce out of the system and pay for it on their own. I don't know what the percentage is. It is probably not very large. That brings me to the one issue which I talked about in my testimony, whether in fact we will allow individuals in the United States to opt out of the global budget and get covered services from an individual provider, hospital or doctor, that is not considered part of the limits.

Most countries in the world have such a mechanism for usually the well-to-do do to opt out of the system.

Mr. McDERMOTT. What I was struggling with was the idea if I live in central Illinois and I go across the river to St. Louis to get my health care, how does the Missouri Health Care Alliance pay for that or how does the Illinois Alliance pay for the patient who has gone across to Missouri?

There must be some mechanism in Canada if you are in—

Mr. ALTMAN. You are focusing on—if you look at his premium limits, it doesn't matter. If you are Plan A and you are in Missouri, it doesn't matter whether your individual goes to Missouri or Illinois or Boston, they pay the rates.

They have to decide what they are going to pay and they have to have contracts.

Mr. McDERMOTT. So the rate for a particular thing in Illinois would differ from the rate for the doctor or the hospital in St. Louis?

Mr. ALTMAN. Yes. They do that now.

Mr. McDERMOTT. Would that be accepted as full payment? Are you assuming balance billing—

Mr. ALTMAN. I think it will be up to the individual plans on how they deal with that relative to their populations. Right now if you join an HMO, some are very restrictive about where you can get your care. That doesn't mean you can't get it in an emergency. If you wind up going to a nonparticipating or a modified participating provider, whether in the same area or far away, you might have to pay 50 percent of the difference.

Mrs. JOHNSON. Will the gentleman yield?

But you are saying contradictory things. If we, as a part of global budgeting, use the national ratesetting system that we have developed in Medicare, then rates are going to be the same whether you are in the system or out of the system. I don't quite understand—

Mr. ALTMAN. I was suggesting looking at premium restrictions, not rates. Therefore, you would say to an individual—this is under one model. Under a model which has a managed competition approach with premium limitations, it goes one way.

Under a rate setting or budget it goes another way. If I sounded inconsistent, it probably was because I was combining them.

Mrs. JOHNSON. I think that is an important point, that they are very different systems.

Mr. ALTMAN. Absolutely. If you are dealing in a premium control system, it is no big deal whether you go to a provider in your region or outside, provided that HMO or managed care plan has a mechanism to pay them.

Mrs. JOHNSON. But you can't have both premium controls and rate setting.

Mr. ALTMAN. Yes, you can.

Dr. EISENBERG. You could if you had a health maintenance organization—

Chairman STARK. If the gentlelady would yield, we have that in Medicare now. We pay a premium for risk contracts and for service rates.

Mrs. JOHNSON. But the private sector is there to pick up our mistakes. We are reimbursing at 65 percent of what everyone else is paying. That 65 percent that they are paying is high because what we are paying is low. I don't see how you mesh them.

Mr. ALTMAN. I think you can, but I think it would put a lot of pressure on the providers to get their spending in line with what they are going to get and it could lead to serious reductions in availability of services.

Dr. EISENBERG. One interesting point is whether or not the fees would be established at the level of the provider or at the level of the individual beneficiary. For example, if that person in central Illinois brought to the doctor in St. Louis his or her care and said, "You will be paid at central Illinois rates which are different from St. Louis' rates," then the inducement to the physician to care for the patient might be different than if the person in central Illinois who goes to a doctor in St. Louis goes to a doctor whose rates have been set because of his own performance.

The effect that that is going to have on border crossing could be profound. You can imagine a scenario where there is a wide difference across States in the fee that we evolve to 10 years from now that would encourage or discourage border crossing one way or the other.

Mr. McDERMOTT. Thank you.

Chairman STARK. Are there other inquiries?

I want to thank you, Stuart, John, Paul, and Don. It was very informative. We appreciate your help.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

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